Patient Information

Last Name: ______________________________ Mr. Mrs. Miss Other: __________ Sex: Male _____ Female _______

First Name: ______________________________ Date of Birth: ___ /___ /_______ Age: _____ SSN: ___ – ___ - __________

Middle Name: ____________________________ Preferred Name: ____

Address: ____City: _______________County:________ State: ____ Zip: ______________

Email Address: ____

Home Phone: ( ) __________________ Cell Phone: ( ) __________________ Work Phone: ( ) ___________________

May we leave a message about appointments or normal test results on the phone numbers you provided? Yes ______ No __________

Would you like to receive appointment reminders via text message? Yes ___ No ___ (If yes, please provide cell phone number above.)

Marital Status: Married Single Separated Divorced Widowed Partner Unknown

Ethnicity: Hispanic or Latino Not Hispanic or Latino Other: _________________________

Primary Language: English Spanish French Other: ______________________________

Race: Caucasian African American Asian Other: _______________________________

Student Status: Not a Student Full Part

Employment Status: Full Part N/A Employer: ____

Pharmacy name: _________________________ Address: __________________________ Phone: ( ) ______________________

Emergency Contact: Name: __________________________ Relationship: _______________ Phone: ( ) ____________________

Alternate Contact: If you want this Practice to contact you at an alternate address or telephone number, please complete:

Alt. Address: ____________________________ City: ______________ State:____ Zip: ________ Phone: ( ) ________________

Referred by: _____________________________________ Primary Care Physician: ________________________________

Guarantor/Financially Responsible Person (if different from patient)

Last Name: ______________________________ Mr. Mrs. Miss Other: ________ Sex: Male ______ Female _______

First Name: ______________________________ Date of Birth: ____/____/____ Age: ____ SSN: ___ – ___ - ____________

Middle: _________________________________ Relationship to Patient: ____

Address: ____ City: __________________________ State: ________ Zip: __________

Home Phone: ( ) __________________ Cell Phone: ( ) __________________ Work Phone: ( ) ___________________

Guarantor/Financially Responsible Person's Email Address: ____

Primary Insurance

Insurance Company: _________________________________

Policyholder Name: _________________________________

Member or Policyholder ID#: __________________________

Policyholder Date of Birth: ___________________________

Insurance Co. Phone #: ______________________________

Group#: ____

Relationship to Patient: ______________________________

Secondary Insurance

Insurance Company: _________________________________

Policyholder Name: _________________________________

Member or Policyholder ID#: __________________________

Policyholder Date of Birth: ___________________________

Insurance Co. Phone #: ______________________________

Group#: ____

Relationship to Patient: ______________________________

Consent for Treatment, Authorization, Assignment of Benefits, and Referral Release

CONSENT FOR TREATMENT: I consent and authorize a Roper St. Francis Physician Partners ("RSFPP") physician or designated qualified assistant to provide me medical treatment and to use and release my protected health information for treatment, payment, and healthcare operations as allowed by HIPAA and as described in the RSFH Notice of Privacy Practices, a copy of which has been made available to me.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I understand that my medical information, including complete medical records, test results, and billing information, may be released to my insurance company and to other medical professionals and/or medical care institutions for treatment and payment purposes.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign all my rights and allow payment to be made directly to RSFPP for all medical or surgical benefits otherwise payable to me under terms of my insurance.

PAYMENT GUARANTEE: I understand and agree that I am responsible for paying all co-payments, co-insurance, deductibles, and non-covered services rendered by RSFPP, including charges for services not covered by my insurance. I consent and authorize RSFPP and third party agents of RSFPP to contact me by telephone at any number associated with me, including a wireless number, and to use a pre-recorded and/or an automatic dialing service in connection with any communication made to me or related to my account.

A photocopy of this form shall be considered as effective and as valid as the original.

To the best of my knowledge the information I have given on this form is accurate and true. I know it is my or my legal guardian's responsibility to keep RSFPP informed of changes to my contact information; a failure to do so may interfere with the ability to contact me concerning my healthcare.

Print Patient's Name: ____

Patient's Signature: ____ Date: ________ /_________ /__________

Print Legal Guardian's Name: ______________________________________

Legal Guardian's Signature: ____ Date: ________ /_________ /__________

Ongoing Communication Regarding Your Healthcare

DO YOU WISH TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM RSFPP MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? (Please provide the information below.)

For **ongoing communication** regarding your healthcare and for your privacy, you must complete this section to authorize RSFPP to release and/or discuss your health information with the following people or entity(s) for the specific dates of service or event(s).

*Any revocation or modification to your authorization with regard to an individual or organization must be submitted in writing.

PLEASE NOTE: By listing an individual(s) and/or entity(s) below, you authorize ALL RSFPP physician offices to release and/or discuss your health information with the individual(s) and/or entity(s).

From date of service/events(s): ______________________ To date of service/events(s): _________________________

Name of Individual/Entity	Phone Number	Relationship	Address
Example: John Doe	*843-555-12121*	*Husband*	*123 Main Street, ABC City, SC 29403*

A separate **Authorization to Release Information Form** must be completed to release and/or discuss your health information with any individual(s) and/or entity(s) not listed in the section above.

To request restrictions of the use of your information, you must complete a separate **Request For Restrictions Form.**

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For your convenience, please list below the individual(s) that you authorize to receive prescriptions from your RSFPP provider(s).

Name of Individual	Phone Number	Relationship	Address

Rev. 09/2017