palmetto advanced therapy services

HIPAA Registration Form

Last Name: _____ First Name: _____ Middle Initial: _____

Preferred Name (if applicable):_____ Status: ☐Child ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Mailing Address: _____ Apt# _____ City:_____ State: _____ Zip:_____County:_____

Social Security Number: _____ - _____ - _____ Date of Birth: _____ / _____ / _____ Sex: ☐Male ☐Female ☐Transgender*

(*Gender Assigned at Birth: ☐Male ☐Female)

Race: ☐American Indian / Native Alaskan ☐Asian ☐Black/African American ☐Hispanic/Latino Native ☐Hawaiian/Pacific Islander ☐White ☐Other

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

Email Address: _____ Primary Care Physician/Provider: _____

Emergency Contact: _____ Phone Number: (_____) _____ Relationship to Patient: _____

Primary Insurance Information

Insurance Company Name: _____

Policy Holder Name:_____

Policy Holder's Date of Birth: _____ / _____ / _____

Policy Holder's Social Security Number: _____ - _____ - _____

Patient Relationship to Policy Holder: _____

Secondary Insurance Information

Insurance Company Name: _____

Policy Holder Name:_____

Policy Holder's Date of Birth: _____ / _____ / _____

Policy Holder's Social Security Number: _____ - _____ - _____

Patient Relationship to Policy Holder: _____

Occupation: _____ Employer (or School if student):_____

How were you referred to us? ☐Family/Friend ☐Physician ☐Internet ☐Insurance ☐Newspaper ☐Phone Book ☐Radio ☐Walk-In ☐Other

If personally referred, whom may we thank for the referral? _____

Guarantor Information (If patient is a Minor or Dependent)

Last Name: _____ First Name: _____ Middle Initial: _____

Mailing Address: _____ Apt# _____ City:_____ State: _____ Zip:_____County:_____

Date of Birth: _____ / _____ / _____ Sex: ☐Male ☐Female Social Security Number: _____ - _____ - _____

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

Relationship to Patient: _____Email Address: _____

Communication Preference

In order for our office to better serve you, please indicate your communication preferences: May we communicate with you by email? ☐Yes ☐No

What is your primary phone contact? ☐Cell Phone ☐Home Phone ☐Work Phone May we send you text messages (i.e. appt reminders?) ☐Yes ☐No

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Acknowledgement of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. We are required by law to maintain the privacy of your health information and to inform you of your rights. The Notice contains a section describing your rights under the law related to your personal health information. You have a right to review our Notice of Privacy Practices before signing this consent.

By signing below, I acknowledge that I have reviewed or had explained to me PPCP Notice of Privacy Practices and agree to continue my care with Palmetto Primary Care Physicians under said terms.

I authorize the following person(s) to obtain medical information about me or my child and allow medical services to be rendered in my absence

Name: _____ Relationship to Patient: _____ Phone Number: (_____) _____

Name: _____ Relationship to Patient: _____ Phone Number: (_____) _____

_____ _____ / _____ / _____

Patient or Guarantor Signature **Date**

Insurance Authorization and Financial Responsibility Disclosure

My signature below authorizes **Palmetto Primary Care Physicians** to release any medical information necessary to process my or my dependent's insurance claim.
I authorize any benefits due be paid directly to Palmetto Primary Care Physicians.

Your insurance company only provides our office an "estimate" of covered benefits prior to receiving any services or materials from us. This "estimate" is not a guarantee of benefits.
I understand that I may be required to pay a deductible, co-pay or co-insurance for covered services, as well as any balance for services not covered by my insurance plan. In the event that my insurance does not cover for services and/or materials rendered to me, I agree to be responsible for payment of all balances on my or my dependent's behalf for those services and/or materials not covered by insurance. I understand that all **fees for professional services shall be paid at time of service and are NON-REFUNDABLE.** Any returned check will incur a $35 fee.

PPCP reserves the right to use the contact information provided in this form by you, the patient, to communicate information regarding your account, including attempts to collect on monies owed to PPCP. We reserve the right to provide your contact information to any third-party for the express purpose of collecting any amounts you may owe for services rendered. By signing this form, you agree that we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers. Method of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.

Please initial each line below to acknowledge practice policies:

_____ I understand I may be charged a fee for missing an appointment without 24 hr advance notification to cancel

_____ I understand I may be charged a fee for any forms or paperwork to be completed by the physician

I certify that I have read and understand the above information to the best of my knowledge.

_____ _____ / _____ / _____

Patient or Guarantor Signature **Date**