Palmetto Internal Medicine
and Primary Care, PA

Patient Information

(please print)
Full legal name: _____ Preferred name: _____
Last *First* *Middle*

Date of birth: _____ SS#: _____
Month/Day/Complete year

Sex at birth: ☐ Male ☐ Female ☐ Intersex
Gender identity: ☐ Man ☐ Woman ☐ Transwoman ☐ Transman ☐ Nonbinary ☐ Another unlisted
What are your pronouns? ☐ He/Him ☐ She/Her ☐ They/Them ☐ Another _____

Primary care physician: _____

Preferred pharmacy name: _____ Phone number: _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life partner ☐ Legally separated
Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Refused/Decline
Race: ☐ Caucasian (white) ☐ American Indian ☐ African American (Black) ☐ Hispanic
☐ Biracial ☐ Asian ☐ Other ☐ Unknown

Home address: _____ City: _____ State: _____ ZIP: _____

Mail to address: _____ City: _____ State: _____ ZIP: _____

County: _____ Home phone: ( ) _____ Cellphone: ( ) _____

Preferred language: _____ Email: _____

Veteran: ___Yes ___No ___Unknown Religion: _____

Guarantor information *(If guarantor is self, skip to emergency contact)*
Parent/guardian presenting minor child for treatment will be listed as the guarantor. If 18 or older, patient will be listed as guarantor and does not have to complete this section. The guarantor will be responsible for any balance due.

Name: _____ Patient relation to guarantor: _____
Last *First* *Middle*
Home phone: ( ) _____

Date of birth: _____ SS#: _____ Cellphone: ( ) _____

Home address: _____ City: _____ State: _____ ZIP: _____ Country: _____

Mail to address *(if different)*: _____ City: _____ State: _____ ZIP: _____ Country: _____

Emergency contact *(Pediatric patients, please list someone other than parent(s)/guardian)*

Primary contact name: _____ Home phone: ( ) _____

Patient relation to emergency contact: _____ Cellphone: ( ) _____

Secondary contact name: _____ Home phone: ( ) _____

Patient relation to emergency contact: _____ Cellphone: ( ) _____

Employment

Patient employer: _____ Work phone: _____ Ext: _____

Address: _____ City: _____ State: _____ ZIP: _____

Employment status: ☐ Full time ☐ Part time ☐ Self-employed ☐ Active military ☐ Student full time
☐ Student part time ☐ Retired date _____ ☐ Disabled ☐ Not employed ☐ Unknown

(Pediatric patients only) Parent/Guardian & immediate family information

Mother *(If the address, phone numbers and employer information are the same as guarantor, please indicate same.)*

Full name: _____ Nickname: _____
Last *First* *Middle*
Date of birth: _____
Month/Day/Complete year

SS#: _____

Home address: _____ City: _____ State: _____ ZIP: _____
(if different from patient)

Home phone: _____ Cellphone: ( ) _____

Employer: _____ Work phone: ( ) _____ Ext: _____

Father *(If the address, phone numbers and employer information are the same as guarantor, please indicate same.)*

Full name: _____ Nickname: _____
Last *First* *Middle*
Date of birth: _____
Month/Day/Complete year

SS#: _____

Home address: _____ City: _____ State: _____ ZIP: _____
(if different from patient)

Home phone: _____ Cellphone: ( ) _____

Employer: _____ Work phone: ( ) _____ Ext: _____

Patient name _____ DOB _____

(Pediatric patients only) Brothers, sisters & other family members

Full name	*M or F*	*Date of birth*	*Relationship*	*Lives with child*	
				Yes	No
				Yes	No
				Yes	No
				Yes	No

☐ **Check here if no insurance. And skip to authorization (below).**

Accident information

Is visit the result of an accident? (Examples: auto accident, workers compensation, etc.) ☐ Yes ☐ No

Type of accident: _____ Date of accident: _____ County of accident: _____

Primary insurance information

SUBSCRIBER: This is the person who carries the insurance. If subscriber is the patient, skip to insurance co. name field.

Subscriber's name on card: _____ Date of birth: _____
Month/Day/Complete year

Patient relationship to subscriber: _____ Sex: ☐ Male ☐ Female

If address and phone number is same as patient, please indicate same.

Address: _____ SS#: _____

City, state, ZIP: _____ Home phone: _____

Employer: _____ Work phone: _____ Ext. _____

Insurance co. name: _____ **Phone:** _____

Policy/Cert #: _____ **Group no.:** _____ **Effective date:** _____

Subscriber Status: ☐ **Full time** ☐ **Part time** ☐ **Self-employed** ☐ **Active military** ☐ **Student full time**
☐ **Student part time** ☐ **Retired date** _____ ☐ **Disabled** ☐ **Not employed**

Secondary insurance information

SUBSCRIBER: This is the person who carries the insurance. If subscriber is the patient, skip to insurance co. name field.

Subscriber's name on card: _____ Date of birth: _____
Month/Day/Complete Year

Patient relationship to subscriber: _____ Sex: ☐ Male ☐ Female

If address and phone number is same as patient, please indicate same.

Address: _____ SS#: _____

City, state, ZIP: _____ Home phone: _____

Employer: _____ Work phone: _____ Ext. _____

Insurance co. name: _____ **Phone:** _____

Policy/Cert #: _____ **Group no.:** _____ **Effective date:** _____

Subscriber status: ☐ **Full time** ☐ **Part time** ☐ **Self-employed** ☐ **Active military** ☐ **Student full time**
☐ **Student part time** ☐ **Retired date** _____ ☐ **Disabled** ☐ **Not employed**

Authorization

I authorize medical evaluation and treatment, and release of information for insurance/medical purposes concerning my illness and treatment. I hereby authorize payment from my insurance company to Palmetto Int Med *for services rendered. I will be responsible for any amount not covered by my insurance.*

Signature of patient/guardian/guarantor: _____ **Date:** _____

Palmetto Internal Medicine and Primary Care, PA
Protected Health Information

PERMISSION TO TREAT

PATIENT NAME: _____

ADDRESS: _____

TELEPHONE: _____ EMAIL: _____

SOCIAL SECURITY: _____ MRN: _____
PIM USE ONLY

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 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 continue to treat me if this consent is revoked.

_____ _____
PATIENT/GUARDIAN SIGNATURE **DATE**

_____
RELATIONSHIP TO PATIENT

Palmetto Internal Medicine
and Primary Care PA

Authorization for Disclosure of Medical Information

Patient Full Name (PRINT) _____ DOB _____ MRN _____
PIM USE ONLY

Authorization for Disclosure of Medical Information: The privacy of your medical information is important. We will discuss your medical condition with person(s) you designate.

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? *(Check and complete one)*

☐ **YES -** The provider may discuss my medical condition with the following family member or other individual:

_____

_____

☐ **NO** The provider may not discuss my medical condition with any family member or other individual.

You may revoke/cancel or modify/change the above designation, but the revocation or modification must be in writing.

NOTE: This designation does not give the above named individuals the right to make health care decisions for you. If at any time you are unable to consent to care or treatment, we will follow the procedure set forth in the South Carolina Adult Health Care Consent Act.

Communication: Please provide phone number(s) where we can reach you (by providing a number you also authorize Palmetto Int Med to leave you voicemails at the number(s) listed):

☐ Home: _____ ☐ Cell: _____ ☐ Work: _____

Note: *An automated appointment reminder system may call the number listed in our data base.*

Signature: I hereby authorize the disclosure of my medical information as described above.

Patient/Patient's Representative Signature: _____ Date: _____Time:_____

PRINT Name (if Patient's Representative): _____

Relationship to Patient (if Patient's Representative):_____

PIM Representative: _____Date: _____Time:____

Palmetto Internal Medicine & Primary Care, PA

Financial Policy

Patient Full Name (PRINT) _____ DOB _____

Please read this financial policy carefully. If you have any questions about this policy, any member of our staff will be glad to assist you.

The following are the conditions for services provided by Palmetto Internal Medicine & Primary Care for the patients whose name appears above.

PROOF OF INSURANCE: Please bring your insurance card to every appointment. We participate with a large variety of insurance plans. If you are not insured by a plan that we participate with, a payment in full is expected at each time of service. It is your responsibility to ensure that we have your correct information and up to date copy of your insurance card.

SELF-PAY PATIENTS: We understand not all patients can afford insurance, that is why we offer self-pay prices at a discount rate. For all self-pay patient's, it is required that you pay up front before every visit and before any service is done.

CO-PAYMENTS, DEDUCTIBLES & CO-INSURANCE: All co-payments, deductibles, co-insurance, & outstanding balances must be paid at the time of service. If you have a deductible, we collect a portion of the deductible up front. You will be required to pay the whole balance on your next visit. If you do not have your copay/co-ins/deductible on the date of service, **YOU MAY BE REQUIRED TO RESCHEDULE.**

CLAIMS SUBMISSION: We will submit your claims and assist you in any way we can to help get your claims paid. Your insurance plan may request information directly from you, it is your responsibility to reply in a timely manner. Remember, your insurance benefits is a contract between you and your insurance plan.

COMPLETION OF MEDICAL FORMS: There may be a charge for completion of forms such as disability, FMLA, etc.

COPIES OF MEDICAL RECORDS: There is a charge for completion of this process; SC Sec. 44-7-325 for Health Care Facilities

- Clerical fee not to exceed $25.00
- $0.65 per page for the first 30 pages, if there are more than 30 pages, the price is reduced to $0.50 per page.
- $15.00 for an itemized bill

A special handling fee of $10 will be charged if records must be delivered within 48 hours of requested date.

NO SHOW APPOINTMENTS: We understand that there may be times you cannot make your scheduled appointments. If need be, you can cancel your appointments via MyChart, our automated reminder system, and by calling our office. We ask that you at least give a 24-hour cancellation notice before your scheduled appointment. If a 24-hour notice is not given, your appointment will be counted as a No-Show. As a courtesy we are no longer charging No-Show fees, but after 4 No-Show or missed appointments you will be dismissed from Palmetto Internal Medicine and Primary Care.

For more information on our No-Show Policy please read our Cancellation and No-Show Policy.

COLLECTION POLICY: If no resolution can be made within sixty (60) calendar days, delinquent actions will be forwarded to a collection agency/or to small claims court and possible discharge from the practice. If you are unable to pay your balance promptly, please call us at 864-277-8300 to make payment arrangements. We will attempt to contact you by phone before your account is forwarded.

QUESTIONS: We are here to help if you should have any questions regarding your statement. **Knowing your insurance benefits is your responsibility. Please contact your insurance plan with questions you may have regarding your coverage**

Patient/Personal Representative Signature: _____ Date: _____

PRINT name of Personal Representative: _____

Palmetto Internal Medicine and Primary Care, PA
Lab Policy

PATIENT NAME: _____

DOB: _____

MRN: _____

PIM ONLY

At Palmetto Internal Medicine and Primary Care, we pride ourselves in offering the best healthcare possible to our patients. By doing this, our providers may at times desire for you to have labs drawn, whether for preventative or diagnostic care.

Although we feel like these labs are a very important part of your healthcare, these labs may not be covered by some insurance companies, and **as the insured that is your responsibility to know your benefits.** In the event that your labs are not covered by your insurance company you will receive a bill from Palmetto Internal Medicine, LabCorp, or both.

By signing this form, you are accepting the responsibility for any uncovered expenses associated with these labs.

_____ _____

PATIENT/GUARDIAN SIGNATURE **DATE**

_____

RELATIONSHIP TO PATIENT

Palmetto Internal Medicine and Primary Care
Cancellation and No-Show Policy

Thank you for trusting your medical care with Palmetto Internal Medicine and Primary Care. When you schedule an appointment with us, we set aside enough time to provide you with the highest quality care. Our goal is to provide quality medical care in a timely manner. To do so we have had to implement an appointment cancellation policy. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please read our Cancellation and No-Show Policy below:

- Effective June 29th, 2023, any established patient who fails to show or cancels/reschedules an appointment without a 24-hour notice will be marked as a No-Show.
- Any patient that continuously cancels or reschedules their appointment will not be rescheduled.
- As a courtesy, and to help patients remember their scheduled appointments, we send out phone call, text message, and email reminders 2 days prior to your appointment.

Our No-Show Policy occurrence is as follows:

- **1st No-Show occurrence**, you will be given a verbal warning by one of our clerical staff.
- **2nd No-Show occurrence**, you will receive a letter from our office notifying you that our No-Show policy has been violated.
- **3rd No-Show occurrence**, you will receive a phone call from our practice manager about the violation.
- **4th No-Show occurrence**, you will be discharged from the practice and notified by letter.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. We understand that there are times when you miss an appointment due to emergencies or obligations for work, or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting needed medical care.

I have read and understood Palmetto Internal Medicine's Cancellation/No Show Policy and understand my responsibility to plan appointments accordingly and notify Palmetto Internal Medicine appropriately if I have difficulty keeping my scheduled appointments.

_____ _____

Patient Name (Please Print) Date of Birth

_____ _____

Signature of Patient or Patient Representative Date

Patient MRN: _____