Hilton Head Regional Physician Network

Patient Information

Last Name (L) | First Name (F) | Middle Name (M)

Previous Last Name | "Nickname" | (Area Code) Home Phone # | (Area Code) Mobile Phone #

Social Security Number | Birth Date (mm/dd/yyyy) | Sex: ☐ Male ☐ Female

Mailing/Billing Address | City | State | Zip

Physical Address (if different from Mailing) | City | State | Zip

Email Address – *Use Personal not Employer*, and the one preferred for Patient Portal Communication

Preferred Method of Contact: _____

Race:_____ Primary Language:_____ Religion:_____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown ☐ Unknown/Not Recorded ☐ Declined to Specify

If Patient is a Minor

Father's Name | Mother's Name | Guardian's Name/ and Relationship to Patient

Relations/Emergency Contact Information (Name of person to contact in case of an emergency):

Last Name | First Name | Relationship to Patient

Area Code/Home Phone | Area Code/Day Phone | Area Code/Mobile/Alternate Phone

Marital Status: ☐ Annulled ☐ Married ☐ Divorced ☐ Polygamous
☐ Interlocutory ☐ Single ☐ Legally Separated ☐ Widowed ☐ Life Partner

Student Status: ☐ Full Time ☐ Part Time ☐ Not a Student

Veteran: ☐ Yes ☐ No

Primary Care Physician | Address | Phone# | Fax#

Patient's Employer Information

Employer | Occupation | Area Code/Work Phone#

Address | City | State | Zip Code | Country

Insurance/Financial Information *(Please present us with all applicable insurance cards)*

Is your visit due to an Auto Accident? ☐ Yes ☐ No If yes, date of Accident:

Is your visit Worker's Compensation? ☐ Yes ☐ No If yes, date of Accident:

Are you personally responsible for payment of fees for services provided by our office? ☐ Yes ☐ No

If no, who is? Guarantor's Last Name Guarantor's First Name Relationship to Patient

Address City State Zip Code Country

Guarantor's Employer Name

☐ *Please review and sign the "Practice Financial Policy and Authorizations".*

Primary Insurance Information

Insurance Company Name

Address City State Zip Code

Enter the name of the person who is the policy holder for the primary insurance:

Cardholder's Name Cardholder's Date of Birth Relationship to Patient

Plan Policy ID# Plan Group # Effective Date

Secondary Insurance Information

Insurance Company Name

Address City State Zip Code

Enter the name of the person who is the policy holder for the secondary insurance:

Cardholder's Name Cardholder's Date of Birth Relationship to Patient

Plan Policy ID# Plan Group # Effective Date

Tertiary Insurance Information

Insurance Company Name

Address City State Zip Code

Enter the name of the person who is the policy holder for the tertiary insurance:

Cardholder's Name Cardholder's Date of Birth Relationship to Patient

Plan Policy ID# Plan Group # Effective Date

Hilton Head Regional Physician Network

Patient Health History Form

Patient Name _____ Birth Date (mm/dd/yyyy) _____

Reason for Today's Visit _____

When did symptoms begin/onset _____

Location: _____

Onset/Select One: ☐ Gradual ☐ Sudden ☐ Other: _____

Frequency/Select One: ☐ Constantly ☐ Recurring ☐ Intermittent

☐ Other: _____

Duration: _____

Severity/Select One: ☐ Minimal ☐ Mild ☐ Mild to Moderate ☐ Moderate

☐ Moderate to Severe ☐ Severe ☐ Incapacitating

Status/Select One: ☐ New Diagnosis ☐ Stable/Unchanged ☐ Improving

☐ Getting Worse ☐ Resolved

Context/When Occurs (eg, when walking, etc.: _____

Aggravated by _____ Relieved by _____

Other symptoms _____

List Any Medications You Are Currently Taking (including non-prescription or over the counter medications, vitamins or supplements): Please indicate name of medicine, dose and frequency for each.

1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

List Any Current Allergies (including medications, food, animal, plant or environmentally:

1.	3.
2.	4.

Past Medical History and Chronic Conditions:

Condition	Date of Onset (Mo/Yr)	Last Addressed (Mo/Yr)	Is this a Chronic Condition?	Condition	Date of Onset (Mo/Yr)	Last Addressed (Mo/Yr)	Is this a Chronic Condition?
☐ Abnormal Xray				☐ Gout			
☐ Abnormal EKG				☐ Headaches			
☐ Allergies (seasonal)				☐ Heart: Murmur			
☐ Anemia				☐ Heart: Attack/MI			
☐ Angina/Chest Pain				☐ Hepatitis, type (A,B,C):			
☐ Anxiety				☐ High Blood Pressure			
☐ Arthritis - Rheumatoid				☐ High Cholesterol			
☐ Arthritis - Osteoarthritis				☐ HIV			
☐ Asthma				☐ Insomnia			
☐ Atrial Fibrillation				☐ Jaundice			
☐ Back Problems				☐ Joint Disorder			
☐ Bladder Infections				☐ Kidney Disorder			
☐ Bleeding/Clotting				☐ Liver Disorder			
☐ Bowel/Colon Problems				☐ Lung Disease			
☐ BPH (Enlarged prostate)				☐ Measles			
☐ Cancer, type:				☐ Migraines			
☐ Cancer, type:				☐ Mumps			
☐ Cancer, type:				☐ Obesity			
☐ Chicken Pox				☐ Osteoporosis			
☐ Chronic Obstructive Pulmonary Disease (COPD)				☐ Peptic Ulcer Disease			
☐ Constipation				☐ Pneumonia			
☐ Coronary Artery Disease				☐ Polio			
☐ Crohn's Disease				☐ Rheumatic Fever			
☐ Depression				☐ Sinus Infections			
☐ Diabetes, Type 1 or Type 2				☐ Skin Disorder:			
☐ Diarrhea				☐ Stroke			
☐ Ear Problems				☐ Substance Abuse			
☐ Eating Disorder				☐ Thyroid Disease			
☐ Epilepsy/Seizures				☐ Tuberculosis			
☐ Eye Problem:				☐ Venereal Disease			
☐ Gallbladder Disease				☐ Other:			
☐ GERD/Reflux				☐ Other:			

Please Indicate Any Past Surgical History:

Surgery	Year	Surgery	Year	Surgery	Year
☐ Angioplasty		☐ Cholecystectomy (Gallbladder)		☐ Pacemaker	
☐ Angioplasty w/Stent		☐ Cesearean Section		☐ Prostatectomy	
☐ Appendectomy		☐ Colectomy		☐ Small Bowel Resection	
☐ Arthroscopy, Knee		☐ Colostomy		☐ Thyroidectomy	
☐ Back Surgery		☐ D & C		☐ Tonsillectomy	
☐ Biopsy, type:		☐ Fracture/broken bone repair		☐ Tubal Ligation	
☐ Biopsy, type:		☐ Gastric Bypass		☐ TURP	
☐ Breast Augmentation		☐ Hernia Repair		☐ Vasectomy	
☐ Breast Reduction		☐ Hip Replacement		☐ Other	
☐ CABG (Open Heart)		☐ Hysterectomy		☐ Other	
☐ Carpal Tunnel Release		☐ Knee Replacement		☐ Other	
☐ Cataract Extraction		☐ LASIK			
		☐ Mastectomy			

Please Indicate if You Have Had Any of the Diagnostic Studies/Tests Below:

Test	Yes / No / NA	Date or Approximate Month/Year
☐ Abdominal Ultrasound		
☐ Chlamydia Test		
☐ Cholesterol Test		
☐ Colonoscopy		
☐ DEXA/Bone Density		
☐ Diabetes Screening		
☐ EKG/ECG		
☐ Flu Vaccine		
☐ Herpes Zoster Vaccine		
☐ HPV Vaccine		
☐ Mammogram		
☐ Pap Smear		
☐ Physical Exam, General		
☐ Physical Exam, GYN & Breast		
☐ Pneumococcal Vaccine		
☐ Prostate Cancer Screen		
☐ Shingles Vaccine		
☐ Td/Tdap Vaccine		
☐ Other:		
☐ Other:		
☐ Other:		

Females - Last Menstrual Period:_____

Please Indicate Any Relevant Family History:

Condition/Diagnosis	Family Member	Age of Onset	Alive & Well?(Y/N)	Cause of Death? (Y/N)

Social History – Tobacco Usage:

Use Tobacco: ☐ Current ☐ Former ☐ Never ☐ Unknown

Type:	Quantity per Day:	Year(s) Used:	Tried to Quit? (Y/N)	Year Quit
☐ Chewing				
☐ Cigar				
☐ Cigarettes				
☐ Pipe				
☐ Smokeless				
☐ Snuff				

Social History – Alcohol:

Alcohol: ☐ Yes ☐ No

Frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐ Occasionally ☐ Rarely ☐ Socially

Social History – Caffeine:

Caffeine: ☐ Yes ☐ No

Type	Quantity per Day
☐ Chocolate	
☐ Coffee	
☐ Energy Drinks	
☐ Soda	
☐ Tablets	
☐ Tea	

Are you enrolled in a Clinical Research Study or Clinical Trial?

[Note to practice staff: in EPM entered on the Client Defined tab on the Modify Patient Information window; in EMR entered by selecting Alerts, checking the box for Research Participant and enter the type of study. Additional information can be recorded under Comments]

☐ No

☐ Yes – Please describe:

Preferred Pharmacy Information *(Please notify us any time you change pharmacies)*

[Note to practice staff: in EMR select Template/Patient Demographics or the Patient Demographics tab in the upper right corner of the screen – middle tab.]

Pharmacy #1

Name Address City State (Area Code) Phone#

Pharmacy #2

Name Address City State (Area Code) Phone#

Patient Signature Date

Hilton Head Regional Physician Network

A federal law was passed in 2014 and became effective on September 30, 2014, governing how we may contact you via telephone, text, and email. Listed below are some of the reasons we may need to contact you via telephone, text, or email:

- Appointment reminders
- Follow up with test results
- Reminder calls about annual preventive care due
- Email or fax with patient forms to complete prior to your appointment
- Notification of medication renewals
- Notification of surgery time and date
- Notification of prepayments for surgeries and procedures
- Follow up calls after surgeries or procedures

Consent to Contact

By providing a telephone number, I expressly consent and authorize the physician practice, any practitioner or clinical provider as well as any of their related entities, agents, or contractors, including but not limited to schedulers, marketers, advertisers, debt collectors, and other contracted staff (collectively referred to herein as "Provider") to contact me through the use of any dialing equipment (including a dialer, automatic telephone dialing system, and/or interactive voice recognition system) and/or artificial or prerecorded voice or message. I expressly agree that such automated calls may be made to any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by, or associated with me and obtained through any source including, but not limited to, any number I am providing today, have provided previously or may provide in the future in connection with the medical goods and services and/or my account. By providing this express consent, I specifically waive any claim I may have for the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing a telephone number, I expressly consent to the receipt of text messages from Provider at any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by, or associated with, me and obtained through any source including, but not limited to, any number I have provided previously or may provide in the future in connection with my account. By providing this express consent, I specifically waive any claim I may have for the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing my email address now or at any time in the future in connection with the medical goods and services provided and/or my account, I expressly opt-in to the receipt of email communications from Provider for or related to the medical goods or services provided, my account, and other services such as financial, clinical and educational information including exchange news, changes to health care law, health care coverage, care follow up, and other healthcare opportunities, goods and services. By providing this express consent, I specifically waive any claim I may have for the sending of such emails, including any claim under federal or state law and specifically any claim under the CAN-SPAM Act, 15 U.S.C.§ 7701, et seq. By providing an email address, I represent I am the subscriber or owner or have the authority to use and provide consent to contact the email address.

I understand that providing a phone number and/or email address is not a condition of receiving medical services. I also understand that I may revoke my consent to contact at any time by directly contacting Provider or utilizing the opt–out method that will be identified in the applicable communication.

I have read and understand the above and consent to contact as described:

Patient Name: _____ Date of Birth: _____

Signature: _____ Date:_____

***Minors or Users Requiring Caregivers – Acknowledgement of Consent to Contact**

Name: _____ Relationship to Patient: _____

Signature: _____ Date:_____

Financial Policy and Authorizations

We are happy that you selected a Hilton Head Regional Physician Network provider for your healthcare needs and look forward to working with you. To help you understand your financial responsibilities in relation to your medical care, we would like to briefly outline our financial policies.

Patients are expected to provide identification and if insured, a current insurance card(s) at time of service. Patients are financially responsible for all services provided and are expected to pay for services at time of service, including any past due balance from a prior date of service. If the patient is a minor child, the parent or other adult accompanying the child will be financially responsible regardless of legal guardianship. Returned checks will be subject to fees.

Medicare: The office will bill the Medicare intermediary. Patients are responsible for the following:

- Annual Medicare deductible
- All applicable co-pays of the allowed charge
- Any non-covered services
- Any covered service ordered by the physician which does not meet Medicare's medical necessity and for which the beneficiary signed an Advanced Beneficiary Notice (ABN).

Medicare Supplemental and Secondary Insurances: The Practice will bill both Medicare and secondary insurances.

Medicaid: Patients must provide the Practice with a current Medicaid card at each visit. Medicaid patients are responsible for applicable co-pays and for all non-covered services. Medicaid patients are responsible for securing necessary referrals from their primary care physicians.

HMOs and PPOs, Commercial Insurance Plans: Patients are responsible for payment of the co-pay, co-insurance and/or deductible, or non-covered amounts at the time of service as well as for any charges for which the patient failed to secure prior authorization, if authorization is necessary. Insurance is filed as a courtesy and benefits are authorized to be paid directly to the Practice. Patients are responsible for the balance in full if not paid by the insurance within 30 days. If the patient is not prepared to pay the co-pay or deductible, a member of the clinical staff will determine if it is medically necessary for the patient to see the physician. If the patient's condition allows, the appointment will be rescheduled.

Self-Pay: Patients are responsible for payment in full at the time of services for all services rendered.

Worker's Compensation: Employer authorization must be obtained before treatment is rendered or the patient will be responsible for payment in full at the time of services for all services rendered. Once authorized, patients are not responsible for any charges unless the workers compensation case is dismissed or denied.

Personal Injury/Motor Vehicle Accidents and Other Third Party Liability: The patient is responsible for the balance in full at the time of service. Any settlement you receive from your insurance company or other third party will be handled by you, your insurance company, and/or your attorney.

Out of State Insurance: If the patient presents with an out of state HMO/PPO insurance card, we will need to verify the patient's benefits for out-of-state or out-of-network benefits. The patient may be required to make payment in full or pay any co-pay, co-insurance or deductible.

Authorizations and Consent

ASSIGNMENT AND RELEASE: I hereby assign my insurance or other third party carrier benefits to be paid directly to the Physician Practice, realizing I am responsible for any resulting balance. I also authorize the Physician to release any information required to process this claim to my insurance carrier and/or to my employer or prospective employer (for employer sponsored/paid for claims). I acknowledge that I am financially responsible for services rendered, and failure to pay any outstanding balances may result in collection procedures being taken. Further, I agree that if this account results in a credit balance, the credit amount will be applied to any outstanding accounts of mine, or to a family member whose account I am guarantor for.

ELECTRONIC CHECK CONVERSION: When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account the same day.

CONSENT FOR TREATMENT: I hereby authorize the physicians, midlevel providers, nurses, medical assistants, and other Practice staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable.

NO SHOW POLICY: I understand if I fail to come for a scheduled appointment or cancel at least 24 hours prior to the appointment, I will be considered a "no show" and may be subject to a "no show" charge per occurrence. Ongoing occurrences of no shows may result in dismissal from the Practice.

I understand the Financial and No Show Policies, Authorizations and Consent for Treatment, and hereby agree to them:

_____ _____

Patient or Parent/Guardian if Minor Date 2-23-2007; Rev 2-13-15; Rev 8-1-15

Hilton Head Regional Physician Network

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGEMENT

A Notice of Privacy Practices (NPP) is provided to all patients and explains: (1) how your Protected Health Information (PHI) may be used or shared; (2) your rights to access or amend your PHI, request information on disclosures of your PHI, and request additional restrictions on our uses and disclosures of PHI; (3) your rights to complain if you believe your privacy rights have been violated; and (4) our responsibilities for maintaining the privacy of your PHI.

- I acknowledge that I have received a copy of the "Notice of Privacy Practices" (Version 3 August 2013 dated 09/23/2013) that explains when, where, and why my Protected Health Information (PHI) may be used or shared.
- I authorize Hilton Head Regional Physician Network to furnish complete information, including Protected Health Information, requested by my insurance carrier or its intermediaries regarding services rendered. I hereby authorize my insurance carrier to furnish to Hilton Head Regional Physician Network any information obtained in the adjudication of any claim for services furnished to me by Hilton Head Regional Physician Network.
- I acknowledge that Hilton Head Regional Physician Network, the physicians, the nurses, and other staff may obtain and share any or all of my Protected Health Information, including prescription history, with other health care professionals in order to treat me, coordinate my care, and/or in order to arrange for payment of my bill and respond to any issues related to my care.
- I acknowledge that I have the right to request additional restrictions on the use and disclosure of my PHI if I so choose.

Name of Patient/ or Guardian (if Minor): _____

Signature of Patient/or Guardian: _____

Date: _____

PATIENT COMMUNICATION CONSENT

We may need to contact you regarding your medical care. This is to acknowledge that you authorize Hilton Head Regional Physician Network to (check all that apply):

☐ Leave a detailed message on voice mail/machine

☐ Call my workplace phone number and leave a message

☐ Call my workplace phone number and speak only to me

☐ Transmit and Receive messages through Patient Portal (NextMD or Other) including secure email

☐ None of the above

I further authorize the disclosure of my PHI to the following individuals or family members:

Name: _____ Relationship to Patient:_____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient:_____

Signature of Patient/Guardian: _____Date of Birth:_____Date:_____

Lady's Island Medical Center
An affiliate of Hilton Head Regional Physician Network

Lady's Island Medical Center, The Shoppes at Hamilton Village - 97 Sea Island Parkway, Suite 203, Beaufort, SC 29907
P: 843-379-0367 | F: 843-379-0368 • www.ladysislandmedical.com

RECORD RELEASE / AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Patient's Name:_____
Last First Middle

Home Address: _____

_____

Home Telephone:_____ **Date of Birth:**_____

SPECIFY INFORMATION TO BE RELEASED OR REQUESTED (CHECK BELOW): The Authorization includes:

☐ Discharge Summary	☐ Progress/Physician Notes	☐ X-Ray Report	☐ Pathology Report
☐ History & Physical	☐ Nurses Notes	☐ EKG/EMG/EEG Report	☐ Consult Report
☐ Emergency Report	☐ Laboratory Report	☐ Operative Report	☐ Entire Record

☐ Other:_____

Records for the period (dates) from _____ to _____

MY HIGHLY CONFIDENTIAL INFORMATION:
By checking any of the boxes next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the category of highly confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization:

☐ Information about mental health or mental retardation services
☐ Psychotherapy Notes created by a mental health professional
☐ Information about HIV/AIDS-related testing (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
☐ Information about sexually transmitted diseases
☐ Information about alcohol or drug abuse treatment program services
☐ Information about sexual assault
☐ Information about child abuse and neglect

☐ **RELEASE INFORMATION TO** ☐ **REQUEST INFORMATION FROM**

Name:_____

Address:_____City:_____State:_____ Zip Code:_____

Phone:_____ Fax:_____

TERM: This Authorization will remain in effect:
☐ From the date of this Authorization until the_____day of_____, 20_____.
☐ Until Lady's Island Medical Center fulfills this request.
☐ Until the following event occurs:_____
☐ Other:_____

PURPOSE: I authorize Lady's Island Medical Center to use or disclose my health information (including the highly confidential information I selected above, if any) during the term of this Authorization for the following specific purpose(s): [Note: "at the request of the Patient" is sufficient if the Patient is initiating this Authorization]

RECORD RELEASE / AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I understand that once Lady's Island Medical Center discloses my health information to the recipient, Lady's Island Medical Center cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that Lady's Island Medical Center may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Lady's Island Medical Center; except, however, if my treatment at Lady's Island Medical Center is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Lady's Island Medical Center may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to Lady's Island Medical Center Privacy Office at the address listed below. The revocation will be effective immediately upon Lady's Island Medical Center receipt of my written notice, except that the revocation will not have any effect on any action taken by Lady's Island Medical Center in reliance on this Authorization before it received my written notice of revocation.

I may contact Lady's Island Medical Center Privacy Office by e-mail at HHH-Privacy@TenetHealth.com.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize Lady's Island Medical Center to use or disclose my health information in the manner described above.

Signature of Patient **Date**

Note: If Patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

Signature of Authorized Personal Representative	Relationship to Patient	Date

Lady's Island Medical Center
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