South Strand Internists & Urgent Care

SURFSIDE BEACH
1945 Glenns Bay Rd.
Surfside Beach, SC 29575
Phone: 843-650-4006
Fax: 843-650-1418

CAROLINA FOREST
185 Fresh Dr.
Myrtle Beach, SC 29579
Phone: 843-945-3030
Fax: 843-903-5232

WELCOME

We are pleased that you chose our practice to serve your healthcare needs. We strive to do our best to make your visits pleasant, comfortable, and satisfying.

Please find your registration packet attached. We ask that you complete each form and bring it with you to your scheduled appointment.

Below is a list of items you will need to have available upon arrival:

- Insurance card(s) – Primary and Secondary (if applicable)
- Identification card – Driver's License or state issued photo ID preferred
- Medication bottles or complete list of current medications
- Insurance co-pay or deductible (if applicable)

(Revised: June 22, 2020)

South Strand Internists & Urgent Care

PATIENT INFORMATION

(Please Print)

Patient Full Name: _____

Date of Birth: _____ Sex: M / F SSN: _____/_____/_____ Marital Status: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____ E-mail: _____

Race: _____ Language: _____ Ethnicity: _____

How did you hear about us? _____

****

Emergency Contact: _____

Relationship: _____ Phone: (_____)_____ Cell: (_____)_____

****

Guarantor Information (Mandatory for Minors)

Legal Guardian Full Name: _____

Guarantor Full Name: _____

Patient's Relationship to Guarantor: Self _____ Spouse _____ Dependent _____ Other _____

Date of Birth: _____/_____/_____ SSN: _____ - _____ - _____ Phone: (_____)_____

Address: _____

City: _____ State: _____ Zip: _____

SIGNATURE: _____ DATE: _____

(Revised: October 4, 2018)

South Strand Internists & Urgent Care

MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____

Why are you here today? _____

What are your symptoms or problems? _____

_____

Please list all allergies: _____

_____

Please list all medications & their doses that you are currently taking: _____

_____

_____

_____

_____

_____

Name of Pharmacy: _____

Location: _____Phone: _____

Please list any previous medical problems including operations or surgery: _____

_____

_____

_____

Please list any health problems in your immediate blood relatives: _____

_____

_____

Patient Signature: _____ Date: _____

(Revised: October 4, 2018)

South Strand Internists & Urgent Care

REVIEW OF SYSTEMS (1 of 2)

Patient Name: _____ Date of Birth: _____

Please review the following and check (√) those that apply to you.

GENERAL:
__ Recent weight gain/amount___
__ Recent weight loss/amount___
__ Fatigue
__ Weakness
__ Fever

SKIN:
__ Easy bruising
__ Rash
__ Hives
__ Sun Sensitive
__ Tightness
__ Nodules / bumps
__ Hair loss
__ Color changes of hands/feet when cold

EARS:
__ Ringing in ears
__ Hearing loss

EYES:
__ Pain
__ Redness
__ Loss of vision
__ Double / blurred vision
__ Dryness
__ Feels like something in eye

NOSE:
__ Nose bleeds
__ Dryness
__ Frequent colds
__ Frequent sinus infections

MOUTH:
__ Bleeding gums
__ Sores in mouth
__ Dryness

THROAT:
__ Frequent sore throat
__ Hoarseness
__ Difficulty swallowing
__ Swollen glands
__ Tender glands

HEART & LUNGS:
__ Pain in chest
__ Irregular heartbeat
__ Shortness of breath AM / PM
__ Swelling in legs
__ High blood pressure
__ Heart murmur
__ Chronic cough
__ Wheezing
__ Coughing up blood

STOMACH & INTESTINES:
__ Appetite changes
__ Nausea
__ Vomiting blood/coffee ground matter
__ Stomach pain relieved by eating
__ Liver problems
__ Constipation
__ Diarrhea
__ Blood in stool
__ Black stools
__ Heartburn

KIDNEY/URINE/BLADDER:
__ Difficulty urinating
__ Pain or burning urinating
__ Blood in urine
__ Discharge from penis or vagina
__ Frequent urination
__ Getting up at night to urinate
__ Vaginal dryness
__ Rash / ulcers
__ Prostate problems

MUSCLE/JOINT/BONES:
__ Morning stiffness lasting how long:
minutes _____
hours _____
__ Joint pain
__ Joint swelling
__ Muscle pain
__ Muscle weakness

ENDOCRINE:
__ Excessive thirst
__ Excessive urination
__ Hot flashes
__ Sexual dysfunction
__ Excessive hair growth
__ Excessive hair loss

NERVOUS SYSTEM:
__ Headaches
__ Dizziness
__ Fainting
__ Muscle spasms
__ Loss of consciousness
__ Sensitivity or pain in hands or feet
__ Memory loss
__ Anxiety

BLOOD:
__ Anemia
__ Bleeding tendency

South Strand Internists & Urgent Care

REVIEW OF SYSTEMS (2 of 2)

Patient Name: _____ Date of Birth: _____

Please list dates of last:

MAMMOGRAM _____

MENSTRUAL PERIOD _____

PAP SMEAR _____

COLONOSCOPY _____

CHEST X-RAY _____

TUBERCULOSIS TEST _____

HABITS:

Do you smoke? YES___ NO___ PAST___ Cigarettes per day_____

Do you drink alcohol? YES___ NO___ Amount per day_____ or week_____

Do you get enough sleep at night? YES___ NO___ If NO, hours of sleep_____

(Revised: October 4, 2018)

South Strand Internists & Urgent Care

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversite: Abuse or Neglect: Food and Drug Administration requirements: Legal

South Strand Internists & Urgent Care

HIPAA NOTICE OF PRIVACY PRACTICES

Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by Law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You, then, have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in the notice.

South Strand Internists & Urgent Care

HIPAA NOTICE OF PRIVACY PRACTICES

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before _____.
We are required by law to maintain the privacy of, and provide individuals with, this notice of your legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

_____
Signature

_____ _____
Print Name Date

(Revised: October 4, 2018)

South Strand Internists & Urgent Care

PRIVACY NOTICE

I, _____, hereby authorize South Strand Internists & Urgent Care to release the following information: My Healthcare Information, Appointment Notices, Prescription and Sample Pick-Up, Billing Inquiries and Notices of Collections to the specific individuals below. (South Strand Internists & Urgent Care will release this information upon verification of identity).

1._____

Name of Individual | Relationship to Patient | Phone #

2._____

Name of Individual | Relationship to Patient | Phone #

3._____

Name of Individual | Relationship to Patient | Phone #

South Strand Internists & Urgent Care may leave messages on my recorder at home, mail notices to my home address, or call me on my cell or at work.

Release of Billing Information and Assignment of Benefits

I hereby authorize the attending and consulting physicians to release information concerning my diagnosis and/or treatment to any insurance company requesting the same for purposes of determining eligibility for payment of insurance benefits. By not signing this authorization, I agree to pay my bill in full at the time the services are rendered.

I hereby authorize payment to any and all physicians involved in my treatment or diagnosis of any benefits specified and otherwise payable to me, but not to exceed the reasonable and customary charges. I understand that I am financially responsible to these providers for charges not covered by this assignment.

You, the patient, have the right to request that we restrict how protected health information about you is disclosed.

I understand and accept the South Strand Internists Policies listed above:

Signature: _____ Date:_____

(Revised: October 4, 2018)

South Strand Internists & Urgent Care

PAYMENT POLICY

Thank you for choosing us as your primary care/urgent care provider. We are committed to providing you with quality and affordable health care. Because patients have had questions regarding patient and insurance responsibility for services rendered, we developed this financial policy to help answer the questions that you may have. Please read the policy below, ask any questions that you may have, and sign and date it in the designated space.

1. Insurance: We participate with most insurance plans, including Medicare. If you are not insured by a plan that we are contracted with, payment in full is expected at each visit. If you are insured by a plan that we contract with, but we cannot verify your coverage, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Note: If you are paying in full for services and we are not billing insurance, you may be eligible for a discount.

2. Co-payments and Deductibles: All co-payments and deductibles must be paid at time of service. This arrangement is part of your contract with your insurance company. We have a legal obligation as a contracted provider to collect deductibles and co-payments at each visit.

3. Non-covered Services: Please be aware that some of the services you receive may be non-covered or not considered necessary by Medicare or other insurances. You must pay for these services in full at time of visit.

4. Credit Card on File Request: For your convenience, if you are an existing patient, we request that credit card information be kept on file for any additional outstanding balances that may be incurred after we bill your insurance or after your visit with us. [If there is non-payment of services after 70 days, we will require that patients give credit card information to keep on file for all services going forward –see item 8 for further explanation] Note: Effective 10/1/2015, all new patients are required to keep credit card information on file.

5. Proof of Insurance: All patients must complete our patient form before seeing the provider. We must obtain a copy of your driver's license or other photo identification card along with your current insurance card.

6. Claims Submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claims is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

7. Coverage Changes: If your insurance changes, please notify us before your next visit so we can make appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be charged to your credit card or billed to you if we do not have a credit card on file.

South Strand Internists & Urgent Care

PAYMENT POLICY

8. Nonpayment: If your account is more than 35 days past due, you will receive an automated phone reminder that you have a balance due. If your account is more than 70 days past due, you will receive a second automated reminder that you have a balance due.

After 70 days if your account is still past due, all future services will require your past due account balance to be paid in full as well as any services that you receive going forward. We will also require that a credit card be kept on file if we have not obtained one already.

If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Please be aware that if a balance remains unpaid, we may refer you to a collection agency and you may be discharged from this practice. If this is to occur, you will be notified that you have 30 days to find alternative medical care. During the 30-day period, our provider will only be able to treat you on an emergency basis.

9. Missed Appointments: Our policy is to charge for missed appointments not canceled within 24 hours. These charges will be your responsibility and will be charged to your credit card or billed directly to you if we do not have credit card information on file. Please help us serve you better by keeping your regularly scheduled appointments.

Note: The current charge for missed appointments is $25 and the amount of the charge is subject to change without notice at any time.

10. Prescription Refills: It is our policy to charge for prescription refills if requested outside of your normal visit. These charges will be your responsibility and will be charged to your credit card or billed directly to you if we do not have credit card information on file. Please be sure to check your medications prior to your visit with the provider so that we may ensure that your medications are refilled at the time of your visit. It is important you keep their regularly scheduled appointments so that you will have enough medication until your next visit.

Note: The prescription refill charge is $10 and the amount of the charge is subject to change without notice at any time.

Our practice is committed to providing the best possible care to our patients. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date

(Revised: October 4, 2018)

South Strand Internists & Urgent Care

PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

The physicians of South Strand Internists & Urgent Care seek to maintain good patient relationships to most effectively achieve the best health possible for each individual. Specific rules and regulations passed by federal and state governments define explicitly what a patient's rights are while under the care of a health provider. For implementation of the President's Consumer Bill of Rights and Responsibilities in health care, you are provided the following:

- **The right to considerate care, safe environment and privacy**
- **The right to participate in and make decisions about your own medical care**
- **The right to refuse treatment**
- **The right to know alternative care options**
- **The right to know the names and positions of those treating you**
- **The right to review medical records with explanation and confidentiality**
- **The right to know facility rules**
- **The right to know the cost of services**
- **The right to have an Advanced Directive (i.e. Living Will)**

Patients must assume responsibility for good health management. They must take an active role in implementing care plans. Patients must:

- **Communicate with his/her doctor and other care givers honestly**
- **Provide care givers with all requested and appropriate information**
- **Follow instructions about his/her care**
- **Ask questions about issues he/she does not understand**
- **Treat caregivers respectfully**
- **Keep current concerning personal and family medical histories**
- **Be knowledgeable about medications prescribed by all caregivers**

(Revised: October 4, 2018)