Patient Information

Palmetto Tri-County Primary Care
201-A West Meeting Street
Lancaster, SC 29720
803-286-4666 / FAX: 803-285-1585

PATIENT

NAME:	LAST		FIRST		MIDDLE		*NICKNAME* */PREFERRED NAME
Birthday:		Sex:	M / F	Civil Status:	S / M / D / W	SS#:	
Home Address:	STREET			CITY		STATE	ZIP-CODE
Home Phone:	( )	Work Phone:	( )	Driver's License:			
(Office Use)	( )	(Office Use)	( )				
Employer:		Occupation:					

GUARDIAN

Please fill out the following information if patient is a minor or student.				SS#:		
NAME:		Relationship:				
Address *(If different)*	☐ Same	STREET	CITY		STATE	ZIP-CODE
Home Phone:	( )	Work Phone:	( )	Driver's License:		
Employer:		Occupation:				
Work Address:	STREET		CITY		STATE	ZIP-CODE

INSURANCE

Primary Carrier:		COVERAGES and BENEFITS:	
Name of Insured:		Co-Pay:	$ or %
Relationship to Patient:	Self Spouse Father Mother	Deductible:	$ per year
Insured's I.D.#:		Physicals?	NO 1 per year 1 per 2 yrs
Insured's Date of Birth:		Hepatitis B?	Yes No If indicated
Group# / Company Name:		Hepatitis A?	Yes No If indicated
Effective Date:		Immunizations?	Yes No If indicated
Primary Care Physician:		Obesity?	Yes No If indicated

ACKNOWLEDGEMENT OF RESPONSIBILITY:
I acknowledge that I am ultimately and personally responsible for this account. Even though this office may file my insurance and verify eligibility, this is not a guarantee of payment by the insurance company for any services that I may receive. I assume full responsibility for any non-covered services, deductibles, or co-payments that my insurance company does not pay.

Signature of Insured Person Date/Time

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:
I hereby authorize my insurance company to make direct payment to the physician and or the office for any medical services rendered by him or under his supervision.

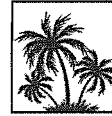
Signature of Insured Person Date/Time

AUTHORIZATION TO PHOTOGRAPH:
I agree to allow the physician or his staff to photograph me (or my legal charge/child) for the purposes of the medical record. I understand that such photographs will never be used in any way which would reveal my personal identity.

Signature of Insured Person Date/Time

AUTHORIZATION TO RELEASE INFORMATION:
I agree to allow the physician or his staff to release to my insurance company any information necessary to secure payment for services rendered.

Signature of Insured Person Date/Time



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Medical History

Date ______________________

Name ______________________ Age __________ Birthdate ______________
Address ______________________ Sex ☐ Male ☐ Female
______________________ Home Phone ______________________
______________________ Work Phone ______________________
Occupation ______________________ Emergency Contact ______________________
Phone ______________________

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If married, spouse's name ______________________

Children's names and ages ______________________

Allergies to Medications, X-ray Dyes, or Other Substances ☐ No ☐ Yes
(If yes, please list name of medicine and type of reaction)

____

Past Medical History and Review of Systems
Please check off if you have had any problems with or are presently experiencing any of the following:

☐ High Blood Pressure	☐ Bronchitis	☐ Change in bowel habits	☐ Arthritis
☐ Diabetes	☐ Pneumonia	☐ Unexplained weight gain/loss	☐ Low back problems
☐ Cancer	☐ Persistent cough	☐ Hemorrhoids	☐ Skin diseases
☐ Heart Disease	☐ T.B.	☐ Gall Bladder disease	☐ Blood disorders
☐ Chest pain/chest tightness	☐ Hay fever	☐ Colitis	☐ Venereal diseases
☐ Shortness of breath	☐ Abdominal discomfort	☐ Hepatitis or jaundice	☐ Anxiety
☐ Swollen ankles	☐ Indigestion	☐ Thyroid disease	☐ Depression
☐ Palpitations	☐ Nausea	☐ Head or neck radiation	☐ Anemia
☐ Lightheadedness	☐ Vomiting	☐ Headache	☐ Alcohol abuse
☐ Frequent urination	☐ Constipation	☐ Kidney disease	☐ Drug abuse
☐ Rheumatic fever	☐ Diarrhea	☐ Kidney stones	☐ Gout
☐ Asthma	☐ Blood in stool	☐ Difficulty urinating	☐ Impotence or Erectile Dysfunction
	☐ Ulcers		☐ Other

____

Gynecologic and Obstetric History

Age at onset of periods __________ Frequency __________ Length of period __________
Pregnancies __________ Births __________ Miscarriages __________
Prolonged or abnormal bleeding ☐ No ☐ Yes (Please describe) __________
Leakage of urine ☐ No ☐ Yes (Please describe) __________
Pelvic pain ☐ No ☐ Yes (Please describe) __________
Abnormal discharge ☐ No ☐ Yes (Please describe) __________
History of abnormal Pap smear ☐ No ☐ Yes (Please describe) __________

This information is for use by your physician as part of your confidential medical record.

Please continue on the next page

Medical History

Name ______________________ Date __________

Please List and Supply the Dates of:

Operations ______________ ______________ ______________

______________ ______________ ______________

Hospitalizations other than for surgery ______________ ______________

______________ ______________ ______________

Immunization history—have you had:

Hepatitis B? ☐ No ☐ Yes When? ________

_Other? ☐ No ☐ Yes When? ________

Pneumovax immunization? ☐ No ☐ Yes When? ________

Flu immunization? ☐ No ☐ Yes When? ________

Tetanus immunization? ☐ No ☐ Yes When? ________

When was your last:

Pap Smear?____________ Breast Exam?____________ Colon Cancer Test? ____________

Mammogram? ____________ Cholesterol check?____________ Prostate exam?____________

Family History Has any member of your family (including parents, grandparents, and siblings) ever had the following?

Illness	Which family members?	Age when diagnosed
Cancer (describe type)		
Hypertension (high blood pressure)		
Heart Disease		
Diabetes		
Strokes		
Mental disease (anxiety, depression, etc.)		
Drug or alcohol addiction		
Glaucoma		
Bleeding diseases		
Other ____________		

Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)

Drug Name	Dose	Drug Name	Dose	Drug Name	Dose

Prevention

Do you wear seat belts?	☐ Yes	☐ No	If no, why not? ____________
Do you wear a bike helmet?	☐ Yes	☐ No	☐ N/A
Do you exercise regularly?	☐ Yes	☐ No	If yes, type, duration and number of times per week? ____________
Do you smoke?	☐ No	☐ Yes	If yes, how many packs per day?____________
Do you drink alcoholic beverages?	☐ No	☐ Yes	If yes, how much per week? ____________
Do you drink coffee?	☐ No	☐ Yes	If yes, how many cups per day? ____________
Do you drink tea?	☐ No	☐ Yes	If yes, how many cups per day? ____________
If there is a gun in your home, do you keep it unloaded and out of children's reach?	☐ Yes	☐ No	☐ N/A
Do you use drugs? (marijuana, cocaine, crack, etc.)	☐ No	☐ Yes	If yes, explain: ____________
Have you ever engaged in any activity which has put you at risk of getting AIDS?	☐ No	☐ Yes	If yes, explain: ____________
Do you wish to be tested for AIDS?	☐ No	☐ Yes	
Have you ever worked with chemicals, paints, asbestos, or other hazardous materials?	☐ No	☐ Yes	If yes, explain: ____________
Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner?	☐ No	☐ Yes	
Do you ever feel afraid of your partner?	☐ No	☐ Yes	☐ N/A
Do you have a "living will"?	☐ Yes	☐ No	
Do you have a donor card?	☐ Yes	☐ No	

Method of birth control?____________

This information is for use by your physician as part of your confidential medical record.

Palmetto Tri-County Primary Care

201-A West Meeting Street

Lancaster, SC 29720

Phone: 803-286-4666

Fax 803-285-1585

Request for Confidential Communication of Protected Health Information

It is frequently necessary for personnel at this practice to communicate lab results, radiology reports, instructions, information about treatment and other items of Protected Health Information with our patients. It is frequently not possible to speak personally or face to face with the patient. In the event that our staff is not able to speak with you (the patient) directly, please give us instructions about communicating with you.

1. Messages may be left at my:
   a. Home Answering Device........................Number____________________________
   b. Work Voicemail......................................Number____________________________
   c. Cell Phone Voicemail.............................Number____________________________
   d. Secure Email...Email______________________________

My home answering device does not identify me by name, but it is appropriate to leave messages for me there.

Circle yes or no

2. Prescriptions, drug samples, written and verbal instructions for treatment or other messages and items of Protected Health Information may be given to:

Name	Relationship	Phone Number

I hereby release, discharge and agree to hold harmless all to whom this consent is given from any liability that may arise from the release of information authorized above. I understand that I may revoke this consent in writing at any time. This consent is valid for one year from the date of signature, unless otherwise revoked in writing.

X ______________________________ X ______________________________
Signature of Patient/Parent/Guardian DATE/TIME

X ______________________________ X ______________________________
Name of Signer PRINTED DATE/TIME WITNESS DATE/TIME

Palmetto Tri-County Primary Care
Notice of Privacy Practices

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

Palmetto Tri-County Primary Care is required by law to maintain the privacy of confidential information. The practice is required to abide by the Notice currently in effect; however, we reserve the right to change the terms of the Notice and to make the new provisions effective for all confidential information that it maintains. Palmetto Tri-County Primary Care will provide individuals or patients with a revised Notice by posting notice in and making copies available upon request to patients. We want you to know about the privacy practices in our office that are intended to safeguard the use and disclosure of your protected Health Information.

Palmetto Tri-County Primary Care is permitted to make uses and disclosures of protected health information for treatment, payment and health care operations, as described in the following examples. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may occur:

- **Treatment** -We will use Protected Health Information to provide, coordinate or manage your health care. 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. We will also disclose Protected Health Information to other health care providers, hospitals, and facilities that are providing or coordinating your treatment
- **Payment** - We will use Protected Health Information, as needed, to obtain payment for healthcare services. This may include specific information that your health care plan may require before it approves or pays for the health care services that we recommend for you, such as determination of eligibility or coverage for insurance benefits, medical necessity, pre-certification requirements, and undertaking utilization review activities.
- **Health Care Operations** -We will use or disclose, as needed, your Protected Health Information to support business activities of the practice. We may use your Protected Health Information for internal auditing and quality assessment activities. We may use your Protected Health Information, as necessary with third party "business associates" that perform various activities (e.g., collection agencies, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use of or disclosure of your Protected Health Information, we will have a written contract that contain terms that will protect the privacy of your Protected Health Information.

The individual has the following rights regarding protected health information:

- **The right to request restrictions on certain uses and disclosures of Protected Health Information.** You may request restriction of your Protected Health Information by completing a "Request for Restriction" form. It is important to note that HIPPA'S Privacy Rule gives all physicians the right to deny patient's requests for restricted use or disclosure of Protected Health Information. While we consider reasonable requests, it is our general policy and practice not to restrict the use of, or disclosure of Protected Health Information that is necessary for providing good treatment, or important for protecting the health and safety of other treatment, or taking care of you. It is our general policy and practice not to restrict the use or disclosure of Protected Health Information when submitting a claim for reimbursement. If you are a minor (less than 18 years old), you may request that we not disclose Protected Health Information to your parents. We will consider this request in connection with our obligations under South Carolina law.

- **The right to receive confidential communications of Protected Health Information, as applicable.** our general policy is to contact you by telephone, at your home telephone number, or by mail at your home address. You will be asked to sign an Authorization for Communication of Protected Health Information giving our office instructions about communicating appointment information, lab results, radiology reports, instructions and/or other information about treatment or other items of Protected Health Information.

- **The right to inspect and copy Protected Health Information as provided in the Privacy Regulation.** This means you may inspect and obtain a copy of health information about you that is contained in a designated set of records for as long as we maintain the Protected Health Information. Under federal law, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in civil, criminal, or administrative action or proceeding, and Protected Health Information that is subject to law that prohibits access to Protected Health Information. You may request access to your Protected Health Information by completing the "Request for Access" form. Our practice is to consider all requests according to our legal responsibilities under the Privacy Rule. We will act on your request within 30 days from the time we receive the completed form. If we are able to grant your request, we will contact you to arrange a time for you to inspect your Protected Health Information. Under the Privacy Rule, we charge you copying costs (supplies and labor) and postage.

- **The right to amend Protected Health Information, as provided in the Privacy Regulation.** You may request to amend your Protected Health Information by completing the "Request to Amend" form. We will provide a written response to your request within 30 days from the time we receive your completed form. We will honor your request if Protected Health Information is incorrect or incomplete. We may not, under the HIPPA Privacy Rule, amend Protected Health Information if it is not a part of the designated record set, if it would not be available to inspect, or if the information is accurate and complete. For example, if your record mistakenly indicates you received treatment for a pain and swelling in your right hand when, in fact your treatment was for pain and swelling in your right foot, clearly that information should be amended. If, however, you want to delete a reference contained in the history that you told the physician that you were feeling "depressed", it would not be appropriate to delete that reference from the Protected Health Information, because it accurately reflected the information you gave the physician. If we accept the requested amendment, we will: (1) amend the Protected Health Information in the designated record set: (2) inform you we have made the amendment and: (3) notify persons who received and may have relied on Protected Health Information that was amended. If we deny your request to amend Protected Health Information, we will; (1) notify you in writing of the basis for that denial; (2) inform you of your right to submit a written statement of disagreement which we will maintain with your record and will include with future disclosures requested; (3) inform you of your right to file a complaint. If you file a written statement of disagreement, we may prepare a rebuttal statement.

- **The right to receive an accounting of disclosures of Protected Health Information we have made.** That right is limited and does not require us to provide you with an accounting of disclosure for; (1) treatment, payment and healthcare purposes; (2) disclosures made to you or your legal representative on your behalf; (3) disclosures made in accordance with a written authorization you signed; or (4) disclosures made before April 14. 2003. To request an accounting of disclosures please complete the "Request for Accounting" form.

- **The right to obtain a paper copy of the Notice from the covered entity upon request.** This right extends to an individual who has agreed to receive the Notice electronically.

Authorization:

We want you to know that Palmetto Tri-County Primary Care's privacy practices for use and disclosure of Protected Health Information is based upon written authorization and your right to revoke in writing that authorization. Palmetto Tri-County Primary Care will not use or disclose your Protected Health Information for purposes other than treatment, payment or health care operations unless permitted or required by law, without your signed written authorization. You may revoke an authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken action in reliance on the use or disclosure indicated in the authorization:
Palmetto Tri-County Primary Care may use and disclose your Protected Health Information in the following instances. You have the opportunity to agree or object to the use of disclosure of all or part of your Protected Health Information. If you are not present or able to agree to object to the use or disclosure of the protected Health Information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest, in this case, only Protected Health Information that is relevant to your health will be disclosed.

- **Others Involved in your care:** unless you object, we may disclose to a member of your family, a relative, close friend, or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care, if you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose Protected Health Information to notify or assist in notifying family members, personal representative or any other person that is responsible for your location of care, general condition, or death. Finally we may use or disclose your Protected Health Information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family and other individuals involved in your health care.
- **Emergencies:** We may use or disclose your Protected Health Information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physician has attempted to obtain consent but is unable to obtain your consent, he may still use or disclose your Protected Health Information to treat you.
- **Communication Barriers:** We may use and disclose your Protected Health Information if your physician attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgment that you intend to consent to use or disclosure under the circumstances.

Palmetto Tri-County Primary Care may use or disclose your Protected Health Information in the following situations without your consent or authorization. These Include:

- **Required by law:** The use or disclosure will be made in compliance with the law and will be limited to the relevant requirement of the law. You will be notified, as required by the law, of any such disclosures.
- **Public Health:** We may use or disclose your Protected Health Information to a public health authority that is permitted by law to collect or receive information. The disclosure will be made for the purpose of controlling disease, injury or disability.
- **Communicable Diseases:** We may disclose Protected Health Information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
- **Health Oversight:** We may disclose your Protected Health Information to a health oversight agency for activities authorized by law such as audits, investigation and inspection. Oversight agencies seeking this information include government agencies that oversee the health care systems, government benefit programs, other government regulatory programs and civil right laws.
- **Abuse or Neglect:** We may use or disclose your Protected Health Information to public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your Protected Health Information if we believe that you have been a victim of abuse, neglect or domestic violence to the government agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.
- **Food and Drug Administration:** We may disclose your Protected Health Information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance, as required.
- **Legal Proceedings:** We may disclose Protected Health Information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosures is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.
- **Law Enforcement:** We may also disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include: (1) Legal processes and otherwise required by law (2) Limited information requests for identification purposes (3) Pertaining to victims of a crime (4) Suspicion that death has occurred as a result of criminal conduct (5) In the event that a crime occurs on the premises of the practice (6) Medical emergency (not on practice's premises) and it is likely a crime has occurred.
- **Coroners, Funeral Directors, and Organ Donation:** We may disclose Protected Health Information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties as authorized by law.
- **Research:** We may disclose your Protected Health Information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your Protected Health Information, has approved their research.
- **Criminal Activity:** Consistent with applicable federal and state laws, we may disclose your Protected Health Information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose Protected Health Information if it is necessary for law enforcement authorities to identify or apprehend an individual.
- **Worker's Compensation:** We may disclose your Protected Health Information as authorized to comply with worker's compensation laws and other similar legally established programs.
- **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 the Privacy Rule.

Individuals may complain to Palmetto Tri-County Primary Care and to the Secretary of the Department of Health and Human Services, without fear of retaliation by the organization, if they believe their privacy rights have been violated. If you have a concern or believe that we may have violated your Privacy rights, we encourage you to bring that to our attention. You may voice your concern by calling 803-286-4666 and speaking to our privacy contact. If you prefer, you may submit a complaint in writing as well. Under no circumstances will we "retaliate" against you for expressing a concern or filing a complaint relating to your Privacy rights. You have the right to contact the Department of Health and Human Services if you believe your Privacy Rights have been violated.

Palmetto Tri-County Primary Care's Complaint Contact Is:

1. Kathy G. Sistare, Practice Manager
2. 803-286-4666.
3. 201A West Meeting Street, Suite A

This Notice is first in effect on April 14, 2003

Palmetto Tri-County Primary Care

Notice and Acknowledgement

Acknowledgement

I acknowledge that I have received the attached Notice of Privacy Practices.

____ __________________

Patient or Personal Representative Signature Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

Palmetto Tri-County Primary Care

Effective 08/03/2012

Financial Policy: The patient will be asked to provide their insurance card (s) at every visit. This is to ensure the information we have is correct, and the patient's plan is current and one which we participate.

Insurance cards with incorrect information can cause unnecessary delays in payment to claims.

Assignments of Benefits: Palmetto Tri-County Primary Care's physicians and midlevel providers are contracted with various Preferred Provider Organizations (PPO's,) we file the necessary forms for you and accept payment directly from your health plan. Your signature under "assignment of insurance benefits," allow us to directly bill for services rendered on the behalf of you.

Co-Payments: The portion of healthcare costs of which you are financially responsible is expected to be paid in full during registration. **This is an insurance company policy.** As required by your plan, **we will collect all co-payments and deductibles.** Your portion is set by the insurance company and you are responsible for any other non-covered billable services. **It is our policy to collect the deductible and/or coinsurance at the time of service.**
We will submit health insurance forms to your carrier. **However, the agreement of the insurance carrier to pay for medical care is a contract between you and the carrier.** It is your responsibility to understand your medical benefits. There may be limitations and exclusion to coverage. The patient is responsible for any bills not paid by their insurance carrier

Uninsured Patients: Uninsured (defined): Patients registered as self pay where no health insurance claim form is generated
In order to address the needs of our patients without insurance, we offer a **44% discount off our standard fees** without discrimination on the basis of race, color, national origin, creed, or any other ground unrelated to the individual' need for service. This discount acknowledges the lower cost involved in billing and collections when a claim does not have to be submitted to a third party payer. In order to qualify, payment must be made IN FULL prior to or upon completion of visit or procedure. This discount applies to all medical services provided and is offered only at time of service. Patient's eligibility for Self Pay Discount is determined by the patient or guarantor completing and signing an application confirming they do not have health coverage.

Automobile Accidents: Palmetto Tri-County Primary Care does not bill automobile insurance carriers or any other insurance for services rendered due to automobile accident. The patient is responsible for full payment at time of service. **There are no discounted services related to visits due to automobile accidents.** The practice will provide patient with receipt and they may file their own claims.

Worker's Compensation: Palmetto Tri-County Primary Care will bill your Worker's Compensation carrier and accept payment made in full **only if we have prior approval from your employer or carrier.** Otherwise, you will be responsible for the entire bill at time of service.

Payment Options: We accept cash, personal checks, debit cards as well as credit cards (Visa/MasterCard/Discover). Palmetto Tri-County Primary Care charges $35.00 for checks returned for insufficient funds. To rectify the account, the patient will be required to pay with cash, money order, cashier's check or credit card.

Missed & Rescheduled Appointments: Patients who miss appointments will automatically be charged as follows: **$20 fee for routine visit, $50 for any missed procedures, appointments scheduled for 30-45 minutes which may include, but not limited to, complete physicals, Pap, Injections, GI Procedures, and $40.00 for new patient no show.** To avoid this charge, we kindly request that you make any appointment changes at least 24 hours before the scheduled visit. This payment is due on or before your next visit.

Medical Form Completion Policy: There is a $25.00 charge to complete disability forms. If you request forms completed for electric wheelchairs, appointments must be made and paperwork completed at the time of exam.

Requests for Copies of Medical Information: Medical records are provided at no charge when the patient is referred by the physician or health care continuation of treatment for a specific condition or conditions. The practice has contracted with Healthport, Inc. to handle all requests for copies of medical records by patients as well as insurance companies, attorneys, etc. Healthport will bill the patient for any charges associated with copying and transferring the patient's medical record.

Lab and Outside Services: We will forward the patient's insurance information with test requisition form for laboratory tests and any diagnostic services that are rendered by independent vendors. We cannot guarantee insurance reimbursement of the recommended test or contract status of the referred facility with the patient's health care plan. Depending upon the patient's insurance coverage, they may receive a separate statement for these services.

Late Payments: Payment is expected in full within 10 days upon receipt of a statement reflecting a charge due and for which the patient is responsible. Unless prior arrangements have been made through a payment plan, a late fee of 24% annual or $5.00 minimum per month will subsequently apply to any unmet balances or outstanding charges. Palmetto Tri-County Primary Care will provide patient with three (3) statements for any balance after insurance payment. If patient has not made payment in full or made payment arrangements with the billing department, the account will be sent to collection agency. The patient will be responsible for any collection expenses associated with the collection efforts. Please contact our billing department with any questions pertaining to a charge or the balance due on your account. If you need to discuss any special needs in the handling of your account, please contact our billing department during regular business hours.

______________________________ Patient Name Print

______________________________ Witness Name Print

______________________________ / ______________ Signature Patient Date/Time

______________________________ / ______________ Signature Witness Date/Time

Palmetto Tri-County
Primary Care

201-A West Meeting Street
Lancaster, South Carolina 29720
Phone: 803-286-4666
Fax: 803-285-1585

PATIENT MEDICARE AUTHORIZATION

PATIENT'S NAME ____

MEDICARE NUMBER ____

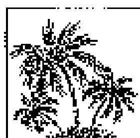
PATIENT'S DATE OF BIRTH ____________________________________

I request that payment of authorized Medicare benefits be made either to me or on behalf to Palmetto Tri-County Primary Care for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payments be made and authorize release of medical information necessary to pay the claim. If other health insurance coverage is indicated in Item 9 of the HCFA~1500 claim form elsewhere on other approved claim forms or electronically submitted claim, my signature authorizes the releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination if the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurances and deductible are based on the charge determination of the Medicare carrier.

Patient Signature ____

Date ____



Palmetto Tri-County
Primary Care

201-A West Meeting Street ▪ Lancaster, South Carolina 29720
Phone: 803-286-4666 ▪ Fax 803-285-1585

Appointment Date____________________________ **Time**__________________

ULTRASOUND EXAM	EXAM TIME	PATIENT PREPARATION & DIETARY RESTRICTIONS
Abdominal Ultrasound	30-40 minutes	Please do not eat or drink ANYTHING 6-8 hours prior to exam. Drink plenty of clear fluids and avoid fatty foods the day prior to exam.
Pelvic Ultrasound	20 minutes	No dietary restrictions, except patient must complete 32oz of water one hour prior to exam. Patient should not empty bladder once they have started drinking.
Abdominal and Pelvic	60 minutes	Please do not eat food 6-8 hours prior to exam. Patient must complete drinking 32oz of water one hour prior to exam. Patient must not empty bladder once they have started drinking.
Renal Artery Duplex	30 minutes	Patient should over-the-counter gas-x. Take as instructed on package at mealtime the evening prior to exam. Try to avoid fatty foods and carbonated liquids the day prior to the exam and drink plenty of clear liquids. Please do not eat or drink anything 6-8 hours prior to exam.
Abdominal Aorta/IVC	30 minutes	Please do not eat or drink anything 6-8 hours prior to exam. Drink plenty of clear fluids and avoid fatty foods the day prior to exam.
Renal/Retroperitoneal	30 minutes	Patient should drink 16oz of water 30 minutes prior to exam. Patient should not empty bladder once they have started drinking.
Echocardiogram	30 minutes	No patient preparation required.
Carotid Ultrasound	30 minutes	No patient preparation required.
Upper/Lower Extremity Arterial Ultrasound	30 minutes	No patient preparation required
Upper/Lower Extremity Venous Ultrasound	30 minutes	No patient preparation required
Breast Ultrasound	30 minutes	No patient preparation required
Testicular/Scrotal	30 minutes	No patient preparation required
Thyroid	30 minutes	No patient preparation required
Prostate Exam	30 minutes	Patient should drink 32 oz of water 30 minutes prior to exam. Patient should not empty bladder once they have started drinking.

NO PATIENT SHOULD WITHHOLD MEDICATIONS. YOU MAY DRINK ENOUGH WATER TO SWALLOW TABLETS. IF YOU ARE DIABETIC, YOU MAY EAT SOMETHING LIGHT AS NEEDED!!

F. Michael Kimbrell, M.D. • Ward Faulkenberry, CFNP
Rita Brown, P.A.-C • Anu Singaraju, M.D. • Brian Snyder, D.O.

Palmetto Tri-County Primary Care

Prescription Refill

It is our goal to make sure you have enough refills until your next appointment, but there may be a time when you will need a medication refilled before your appointment. If you need a refill before your appointment, you should contact your pharmacy and they will contact our office with your request. The process does take 48 hours, so it is important that you not completely run out of your medication. If the refill is not appropriate, the pharmacy may ask you to call the office. Otherwise, you will not have to contact the office at all. We would like to keep this process as smooth as possible to save you time and to better serve you. All narcotic prescription do require an office visit.

Palmetto Tri-County Primary Care

Emergency and After hours call

If you have an emergency, please go to the nearest emergency room or call 911. Our office hours are Monday-Thursday 8am-PM, Close for lunch from 12:30-1:30. Friday 8am-12:PM. If you would like to speak with the on call doctor please call 287-0362.

Palmetto Tri-County Primary Care

No Show Appointments Policy

No Show appointments have an impact on the physician's schedule and can also pose a health risk to the patient. No Show appointments waste resources and prevent other patients from receiving care in a timely manner.

A No Show is an appointment that is:
- Missed without notice
- Missed with less than 4 hours notice

If you must miss an appointment, please notify our office by phone or email the day before the appointment or 3 days before a new appointment. Messages are acceptable and can be left at all times including weekends and nights.
CMS (Centers for Medicare) has now clarified that they will allow physicians and other providers to charge Medicare beneficiaries for missing appointments, provided that they do not discriminate against Medicare patients and also charge non-Medicare patients for missed appointments.

The fees for No Show are as follows:
- New appointment -$40.00
- Return Appointment-$20.00
- Physical Exam- $40.00
- Procedure (EGD, Stress Test, etc.) $50.00

The patient will be notified of No Show fee by mail. These fees must be paid prior to being seen at the patient's next visit. The patient is responsible for any No Show fees, Medicare or other insurance companies will not be billed.

When a patient misses an appointment or is a "No Show", the staff will make every effort to contact patient and if possible, find out why the appointment was missed. If patient consents, appointment will be rescheduled at that time.