Main Street Medical

93 Main Street
Hilton Head, SC 29926

Patient Information:

Patient Name:_____ **Date:**_____
First M Last

SSN:_____ **Male**__ **Female**__ **Date of birth:**_____

Local Phone:_____ **Home Phone:**_____ **Cell Phone:**_____

Street Address:_____

City:_____ **State:**_____ **Zip:** _____

Billing Address (if different):_____

Email address: _____@_____

Marital Status: _____ **Ethnicity (circle): Caucasian/Black/Asian/Hispanic/Other**

Referred By:_____ **Are we your Primary Care Physician: Yes**__ **No**__

Insurance Information:
Name of Insured_____ **Relationship to Patient**_____

SSN:_____ **Birth date:**_____

Medical History:
Current Problems:_____

Drug Allergies:_____

Current Medications:_____

Past Medical History:_____

Family History:
Father- Alive__ **Deceased**__ **Health Problems:**_____

Mother- Alive__ **Deceased**__ **Health Problems:**_____

Social History:
Occupation:_____ **Employer Name:**_____

Amount of Alcohol Consumed:_____ **Amount of Tobacco:**_____

Any History of Drug Use, if so what and when:_____

Emergency Contact:_____ **Emergency Phone #:**_____

Relationship to Patient:_____

_____ _____
Signature of Patient or Guardian **Date**

Main Street Medical

FINANCIAL RESPONSIBILITY AGREEMENT

- Payment is required at the time of service. Payment may be made by cash, check or major credit card. Any deductible, co-insurance or co-payment is payable at the time of service.
- In the event the patient or guarantor does not pay the co-pay or deductable on the date of service, a ten dollar ($10) fee will be applied to the account upon each occurrence.
- The verification of insurance benefits does not guarantee payment of benefits at the time of service. The undersigned agrees, whether being the patient or guarantor, to guarantee payments of the account in accordance with the standard rates and terms of Main Street Medical. I further understand that any balance remaining after insurance approves or denies payment is my responsibility to pay.
- Main Street Medical will submit claims to the insurance companies that we participate with as part of our contractual agreement with them. If no payment has been made to us after ninety (90) days from the date of service the billed amount becomes the patient's responsibility. In the event a wrong insurance card is presented to us on the date of service it is the patient's responsibility to correct the insurance card associated with the claim prior to the 90th day of the date of service. No claims will be submitted to an insurance company after 90 days from the date of service.
- Main Street Medical reserves the right to add a twenty dollar ($20) late fee to the patient's account if payment has not been received by Main Street Medical after 60 days from the date the first bill was mailed. If no payment has been received within ninety (90) days, the balance on the account will be submitted to a collections agency.
- I authorize Main Street Medical to release any information to all my insurance carriers, third party payers, including Health Care Financing Administration (Medicare) or its agents, or the Social Security Administration, as may be required or requested for the processing of health insurance claims. I requested payment of the benefits to be made directly to Main Street Medical, P.C.
- If you have blood work that is sent to a lab (i.e. Quest, Lab Corp, Doctor's Lab), you may be receiving a bill from that facility that is independent from our bill. You will be responsible for this bill.
- If your check is dishonored from your bank account you hereby understand that your account will be charged for the face value of the check plus a thirty dollar ($35) return check fee.

I have read and understood all of the above and have given truthful information to the best of my knowledge.

Printed Name:_____ Date of Birth:_____

Signature:_____ Today's Date:_____

MAIN STREET MEDICAL, P.C.

MAIN STREET MEDICAL, P.C. HAS MADE THEIR PRIVACY POLICIES AVAILABLE TO ME, BY POSTING THE INFORMATION IN THE OFFICE, AND WITH OTHER LAMINATED COPIES OF THE POLICIES WHICH I MAY BORROW TO READ.

IF I HAVE ANY OTHER QUESTIONS, I MAY CONTACT THE PRIVACY OFFICER, AT 843-681-3777 DURING REGULAR BUSINESS HOURS.

PATIENT SIGNATURE: _____

DATE: _____

Patient consent form

Main Street Medical

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Main Street Medical to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Main Street Medical reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Practice Manager at Main Street Medical, 93 Main St, Hilton Head, SC 29926.

With this consent, Main Street Medical may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Main Street Medical may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Main Street Medical may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Main Street Medical restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Main Street Medical to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Main Street Medical may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

_____
Print Name of Patient or Legal Guardian, if applicable