515 River Crossing Dr, Suite 200
Fort Mill, SC 29715
Phone 803-835-6500
Fax 803-835-1990

Please note that we do not perform Annual Preventive Care Exams/Physicals during first time visits; we like to dedicate this time for you to meet your provider, go over medical history and address any current concerns. These visits can be scheduled after you have been established as a patient. Please sign below acknowledging that you understand your initial visit will be billed as a problem-oriented visit.

Date:_______________ Signature: ________________________________

PATIENT INFORMATION

Last Name:________________________________ First Name:_____________________________ MI:_______
Address:__________________________________ Home Phone:________________ Cell Phone:______________
City:_____________________________________ Date of Birth:______________________
State:______________ Zip:________________ Marital Status:______________________ Sex: M or F
SS#:_____________________ Email:____
Employer__________________________________ Employer Address:__________________________________
Work Phone:_______________________________
Emergency Contact:__________________________ Relationship:___________________________
Emergency Contact Work Phone:________________ Emergency Contact Home Phone:______________
Primary Insurance:__________________________ Secondary Insurance:______________________
Preferred Pharmacy:_________________________ ☐ Please initial to allow Patel Medical Clinic to have access to your prescription history

GUARANTOR INFORMATION
(PERSON RESPONSIBLE FOR PATIENT AND ACCOUNT)

Last Name:________________________________ First Name:_____________________________ MI:_________
Address:__________________________________ Home Phone:_________________ Cell Phone:______________
City:_____________________________________ Date of Birth:____________________
State:______________ Zip:________________ SS#:_______________________ Sex: M or F
Relationship to Patient:_______________________ Employer: ______________________ Work #:_______________

SUBSCRIBER & INSURANCE INFORMATION
(PERSON WHO CARRIES THE INSURANCE COVERAGE)

☐ *Same as Guarantor*

Last Name:________________________________ First Name:_____________________________ MI:_________
Address:__________________________________ Home Phone:_________________ Cell Phone:______________
City:_____________________________________ Date of Birth:____________________
State:______________ Zip:________________ SS#:_______________________ Sex: M or F
Relationship to Patient:_______________________ Employer: ______________________ Work #:_______________

Please have your insurance card with you. We will need to make a copy. Please bring all prescriptions with you on every visit. Prescription refill requests should be handled during your office visit.

PATEL MEDICAL CLINIC

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Patient Financial Responsibilities and Policies

Thank you for choosing Patel Medical Clinic for your medical needs. The following patient financial responsibilities and policies have been established to assist us providing the highest quality medical care.

Insurance: It is your responsibility to know and understand your coverage and benefits. As a courtesy, we will file your insurance forms from our office. Please make sure your insurance and demographic information is kept up to date with our office. This includes any change of information such as address, phone numbers, and insurance changes. If the patient is not the policy holder on the insurance, we require the policy holder's full name, date of birth, social security number and relationship to the patient to file all claims. Patients are responsible for all fees at the time of service that are not covered by insurance, including co-payments, coinsurance, deductibles and non-covered services or items received. **At every visit, please make sure you have all insurance card(s) and photo identification as well as any other forms that may assist us in processing your claims correctly.**

No Insurance: If you are not covered by insurance at the time of service, please be advised that you will be responsible for all charges incurred at the time of service. Cash or credit card is accepted.

Returned Check: There will be a thirty dollar ($30.00) charge assessed for any check returned by your bank for any reason.

Past Due Balances: Accounts that are not paid within sixty (60) days from the date of service may be sent to our in house collections department. A collection fee may be added to the balance. If acceptable terms cannot be reached to satisfy the past due balance, the patient may be dismissed from our practice.

Dismissal Process: There are several reasons that a patient may be dismissed from our practice. A few reasons are as follows:
Failure to keep scheduled appointments
Being verbally or physically abusive to staff
Failure to meet financial obligations
A certified letter will be sent to your last known address notifying you that you are being dismissed from our practice. If you have a medical emergency within thirty (30) days of the date of the letter, one of our providers will be available for advice. After the thirty (30) days, you will no longer be seen at our practice by any provider. A copy of your medical record may be forwarded to your new doctor after a formal request is made and applicable fees (if any) are paid.

Patient Acknowledgement:
I, ____ (print name) have read and agree to the **Patient Financial Responsibilities and Policies.** I agree to pay at the time of service. I also understand that Patel Medical Clinic, P.A. reserves the right to dismiss patients that fail to keep their accounts current after reasonable attempts to collect payments have been made. I further agree to pay all reasonable costs and late fees should my account be turned over to collections.

_______________________________________ ___________________

Patient's or Responsible Party's Signature **Date**

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Authorization for Release of Patient Information

Name of Patient ____________________________________ Date of Birth ________________

Patel Medical Clinic is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
❑ Voice Mail	❑ Results of lab tests/x-rays ❑ Other________________________________
❑ Spouse	❑ Financial ❑ Medical as follows:_____________________ _____________________________________
❑ Parent (provide name) _____________________________________	❑ Financial ❑ Medical as follows:______________________ _______________________________________
❑ Other (provide name) __________________ ____________________________________	❑ Financial ❑ Medical as follows ______________________ _______________________________________

Patient Information
I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

____Date________________
Signature of Patient or Personal Representative

____
Description of Personal Representative's Authority (attach necessary documentation

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Acknowledgement of Receipt

Of Notice of Privacy Practices

Patient Name & Address: ____

____

____

I have received a copy of the Notice of Privacy Practices for the above named practice.

____________________________________ ________________________

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason: ____
- ❑ Other:____
  ____

Prepared By ____

Signature ____

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No Show Policy

Please make note of our practice's No Show Policy:

Calling to cancel or reschedule your appointment on the same day you are scheduled to see Dr. Patel will be considered a No Show or Same Day Cancellation; we require 24 hours notice if you are unable to make it to your appointment.

The first No Show or Same Day Cancellation will be excused.

The second No Show or Same Day Cancellation will result in a $20 fee that must be paid before you are able to see Dr. Patel.

The third No Show or Same Day Cancellation is reason for termination from our practice.

We understand that emergencies do arise and those situations will be taken into consideration.

Please sign and date below stating that you have read and understand Patel Medical Clinic's No Show Policy.

__________________________________ ____________________

Patient Signature Date