PALMETTO DIGESTIVE HEALTH SPECIALISTS

Patient Registration
Palmetto Digestive & Endoscopy Center
2073 Charlie Hall Blvd., Charleston, SC 29414
Phone: (843) 571-0643 Fax: (843) 571-0311

Name _____ **Today's Date:** ____/____/____

Social Security # _____ **Date of Birth:** ____/____/____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced **Gender:** ☐ Male ☐ Female ☐ Other

Home Address _____

City _____ State _____ Zip _____ County of Residence _____

Home Phone # (____) _____ Cell Phone # (____) _____

Preferred method of communication: ☐ Home ☐ Cell **E-mail:** _____

Authorized Emergency Contact

Name _____ Phone # (____) _____

Name _____ Phone # (____) _____

Preferred Language _____

Race: ☐ Caucasian ☐ Black or African American ☐ Asian ☐ Other ☐ Patient Declines

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient Declines

Referred to Palmetto Digestive Disease by _____

Primary Care Provider (First and Last name) _____

Pharmacy Name: _____ Location _____

Mail Order Pharmacy Name _____ Phone # _____

Prescription Insurance Company _____

Primary Insurance

Plan _____

ID # _____

Group # _____

Name of Policy Holder _____

D.O.B. of Policy Holder _____

Secondary Insurance

Plan _____

ID # _____

Group # _____

Name of Policy Holder _____

D.O.B. of Policy Holder _____

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Patient Directed Agreement for Release of Health Information

Patient Name: _____ Date of Birth: _____

I agree and offer no objection to the release of protected health information by the above-named provider to the persons indicated below:

Person/Entity	Relationship	Telephone Number

- I understand that this agreement will expire in 12 months from the date of signature.
- I understand that I may object to future disclosures of information by revoking this agreement I can revoke this agreement at any time by contacting the above-named provider/practice either in writing or in person.
- Revocation will not apply to information that has already been disclosed.

_____ _____

Signature of Patient/Authorized Person Date

_____ _____

Relationship Reason if unable to sign

If the patient is not present or is unable to agree, object to the use and/or disclosure of protected health information because of incapacity or an emergency circumstance, the practitioner may use professional judgment to determine whether the disclosure is in the best interest of the individual and if so, disclose only protected health information that is directly relevant to the person's involvement with the individual's health care. The practitioner may also use professional judgement, experience with common practice and the best interest of the patient in also allowing the listed individuals to act on behalf of the patient to pick up filled prescription, medical supplies, x-rays, or the other forms of protected health information.

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Financial Policy

Palmetto Digestive and Endoscopy Center has a responsibility to provide quality healthcare services to patients. In the interest of maintaining a good doctor-patient relationship and continue the delivery of quality healthcare, it is our hope that you will take responsibility for your financial obligation to our practice. Following are general policies we have established for our patients, which we believe allow flexibility that some patients need. We encourage you to discuss your account, and any payment arrangements you desire, with our financial counselor or billing specialist. Discussion of these issues early on in your treatment process will prevent most concerns and misunderstandings.

_____ (initial)
- ***Insurance:*** As a courtesy to our patients, we will file claims on all visits and procedures, whether they are delivered in our office, endoscopy center or hospital. When we file a claim on your behalf, it is with understanding that benefits will be assigned to Palmetto Digestive and Endoscopy Center. **You are responsible for payment of deductibles, co-pay, co-insurance and non-covered services. They will be collected at the time of service.** Please remember that your insurance coverage is a contract between you and the insurance company. The ultimate responsibility for understanding your insurance benefits and for payment to your doctor rests with you.

_____ (initial)
- ***Referrals:*** You are required to know whether or not your insurance company requires a referral from your primary care physician and obtain that referral before you are scheduled to see our physicians. Our office will be happy to assist you in determining the status of any one of our doctors on your insurance plan: however, this never a guarantee of coverage. You should take the time to call your insurance company to ask specifically about the doctor you wish to see and your covered benefits. Referrals typically have an expiration date and a limited number of visits so you should be careful to monitor dates and visits. Our office will not see a patient that does not have a valid referral.

_____ (initial)
- ***No Insurance:*** Patients who do not have insurance are expected to pay for services rendered. We will request a payment for outpatient procedures 48 hours in advance of having the procedure performed. We understand that individual situations may make it difficult to meet these financial expectations and are happy to discuss other payment arrangements if needed. Our office does offer a self-pay discount if services are paid in full at the time they are received.

_____ (initial)
- ***Returned Checks:*** Your account will be charged a $35 fee for each returned check, in addition, you will be asked to bring cash for the returned check and the fee.

_____ (initial)
- ***Past Due Accounts:*** Patients who have not made an effort to make payment arrangements or have not expressed an interest in meeting their financial obligation to us may be turned over to a collection agency. Patients who have allowed their account to be turned over to a collection agency will be expected to satisfy the financial obligation (old balance), and pay for any future services in advance, before being seen by our physicians or having a procedure done. **Payment plans can be arranged and payments are made monthly.**

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_____ (Initial)

- ***Out of Network Services:*** Palmetto Digestive and Endoscopy Center cannot make any guarantees that lab work we order, pathology, anesthesiology or other professional services are in-network with your insurance plan. Please note that you are responsible for any charges in conjunction with services you receive at our facility whether these are considered in or out of network with your insurance company.

_____ (Initial)

- ***Non-covered services:*** We believe that your visit is relevant to evaluate, monitor and protect health. However, Medicare and certain other insurance companies will only pay for services that they determine to be "reasonable and necessary", then they will deny payment for the service. Sometimes an insurance company will not cover an office visit prior to a procedure when the patient comes to the doctor with no symptoms and is requesting a screening procedure. Denial of payment by your insurance company does not mean that you do not need to visit the physician or physician assistant beforehand.

_____ (Initial)

- ***Office Visit Cancellation/No Show:*** Due to high demand, we require you to call 48 hours in advance at 843-571-0643 should you need to cancel your appointment. If you "no-show" to your appointment twice, you will be released from the practice and your PCP will be notified of the event.

_____ (Initial)

- ***Surgery Cancellation:*** Appointments not cancelled withing 48 hours prior to surgery will be charged a $250.00 "No Show" fee. This will be an out-of-pocket expense which will be reflected in your billing statement.

Patient Statement:

I have been informed of Palmetto Digestive and Endoscopy Center's financial policy and agree to its terms. I have been advised that Medicare and other insurance companies may deny payment for my initial office visit for the reasons stated above. If Medicare or my insurance company denies payment, I agree to be personally and fully responsible for payment.

_____ Patient Signature

_____ Date

_____ Printed Name

_____ Date of Birth

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Authorization and HIPAA Acknowledgement

I authorize and request Palmetto Digestive and Endoscopy Center to render me reasonable and proper medical care based on today's standards for practice of medicine. I certify that all my demographic information on file is correct. I consent to be treated by staff and providers of Palmetto Digestive and Endoscopy Center and its affiliates, and authorize them to release any medical information necessary to process medical insurance claims. I understand that I am responsible for co-payments, deductibles, co-insurance and non-covered services. I have received notice of Palmetto Digestive and Endoscopy Center's privacy practices and my rights concerning my protected health information.

I further acknowledge the opportunity to read and I was given the opportunity to request a personal copy of the Palmetto Digestive and Endoscopy Center's HIPAA Notice of Privacy Practices.

Patient Signature: _____ Date: _____

Print Name: _____