CONWAY PHYSICIANS GROUP PATIENT DEMOGRAPHICS

DATE:

PATIENT INFORMATION

Patient Name	DOB	Age	Check Gender: ____M ____F

Address	Home Phone	Cell Phone
City/State/Zip	SS#	E-Mail
Race Religion	Highest Level of Education	Ethnicity Preferred Language
Emergency Contact	Relationship	Emergency Phone #

Pharmacy	Primary Care Provider Name

PATIENT EMPLOYMENT INFORMATION

Employer	Work Number

GUARANTOR INSURANCE INFORMATION

Primary Insurance Information

Primary Insurance	Employer	Policy #	Group #
Insured Name	Address	City/State/Zip	Insured DOB Insured SS#

Secondary Insurance Information

Secondary Insurance	Employer	Policy #	Group #
Insured Name	Address	City/State/Zip	Insured DOB Insured SS#

REFERRAL INFORMATION

How did you hear about us?

CONSENT FOR HEALTHCARE & RELEASE OF MEDICAL INFORMATION

I voluntarily consent to treatment at this facility by its physicians and staff. No guarantees have been made to me about the results of treatment of examination by staff at this practice. I consent to the use and disclosure of my protected health information and treatment, payment and healthcare operations. I have read this form and had the opportunity to ask questions.

CANCELLATION & NO SHOW POLICY

Recognizing that everyone's time is valuable and the appointment time is limited, we ask that you provide a 24 hour notice if you are unable to keep your appointment. Conway Physicians Group reserves the right to charge a fee of $25.00 for each missed (No Show) appointment, which is, absent for a compelling reason, and is not cancelled within a 24 hour advance notice. "No Show" fees will be billed to the patient and not covered by insurance.

FINANCIAL RESPONSIBILITY & ASSESSMENT OF INSURANCE BENEFITS

I authorize Conway Physicians Group to bill my insurance company using the information I have provided to this office for payment to their Medical Facility. I assign payment for the unpaid charges for certain physician services to Conway Physicians Group. I understand that I am respondible for any health insurance deductible and co-insurance payments. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any medical or any other information about me to be released to the Social Security Administration or its intermediaries or carriers and any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

SURESCRIPTS & HEALTH INFORMATION EXCHANGE AUTHORIZATION

In accordance with SC State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that Conway Physicians Group uses Commonwell, an organization Cross-vendor interoperability is necessary to improve health care delivery and outcomes as well as SureScripts, INC., a prescription system that allows prescriptions to be exchanged between my providers and pharmacy. The information sent between these systems may include details of any and al prescription drugs I am currrently taking and/or have taken in the past. This authorization may include disclosure related to alcohol and drug abuse, mental health, or HIV related treatment. I have the right to revoke this authorization at any time. This authorization is voluntary and does not authorize Conway Physicians Group to discuss my health information or medical care with anyone other than those permitted under applicable law.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Privacy Practices are locted in the main lobby for review and may be offered a copy at my request. I am aware that the notice may be changed at any time and that I may request a copy of the revised notice by contacting Conway Physicians Group administration.

SIGNATURE OF AUTHORIZED PERSON: **DATE:**

CONWAY PHYSICIANS GROUP RELEASE OF INFORMATION

COMPOUND RELEASE OF HEALTH INFORMATION

Patient Name	DOB

Conway Physicians Group 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.

PERSON AUTHORIZED TO RECEIVE PROTECTED HEALTH INFORMATION ABOUT YOU:

Check each person/entity that you approve to receive information

☐ **SPOUSE** (Provide Name)

Authorized to Receive Information Regarding: _____Financial Information _____Medical Information

☐ **PARENT** (Provide Name)

Authorized to Receive Information Regarding: _____Financial Information _____Medical Information

☐ **EMPLOYER** (Provide Name)

Authorized to Receive Information Regarding: _____Financial Information _____Medical Information

☐ **SCHOOL** (Provide Name)

Authorized to Receive Information Regarding: _____Financial Information _____Medical Information

☐ **REFERRING PHYSICAN** (Provide Name)

Authorized to Receive Information Regarding: _____Financial Information _____Medical Information

☐ **OTHER** (Provide Name)

Authorized to Receive Information Regarding: _____Financial Information _____Medical Information

I give authorization for the release of protected health information on voicemail.

☐ Yes ☐ No

Authorized to receive information regarding:

☐ Results of tests that are normal (including but not limited to lab and x-rays)

☐ Appointment information

☐ Prescription Refill Information

☐ Other information as follows:

RIGHTS OF THE PATIENT

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 by sending a written notification to Conway Physicians Group. 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.

SIGNATURE OF AUTHORIZED PERSON: **DATE:**