

## Carolina Medical Consultants, P.A. New Patient Information

*Welcome to our office!*

Date \_\_\_\_\_

Patient's Name (Please Print)				Marital Status				Sex		SSN #		Date of Birth	
				S	M	W	D	Sep	M				
Mailing Address				City and State				Zip Code		Home Phone #			
Patient's Employer				Business Address				Cell Phone #		Business Phone #			
Insurance Carrier				Policy #				Group #					
Address				Phone #				Spouse		Child		Other	
								Relationship to Insured					
Insured's Name				SS #				Birthdate					
Insured's Employer				Business Address				Business Phone #					
Notify in Case of Emergency				Relationship				Phone #					

### PLEASE READ THE FOLLOWING INFORMATION:

- This office participates with many insurance plans, including Medicare/Medicaid. We will file your visit if we participate with your insurance company. If we do not participate with your insurance plan, payment is expected at the time of service.
- Patients are responsible for notifying the business office of any changes in insurance coverage and changes of address.
- Plan co-payments are due at the time of service.
- Patients are responsible for balances due to deductibles, copayments, or insurance non-payment according to their plan.
- Patients are responsible for notifying the Patient Co-ordinator if referrals are needed to a specialist.

I consent to treatment necessary for the care of the above named patient. I authorize the release of medical information necessary to pay a claim or to any of our agents. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. I further authorize and request that insurance payments be made directly to Carolina Medical Consultants, P.A. should they elect to receive such payment.

In the event a physician or medical facility requests your PHI for the purposes of continuation of care, I authorize Carolina Medical Consultants to release all medical records including information relating to drug, alcohol, psychiatric conditions, and/or sexually transmitted disease, including HIV/AIDS information. I agree to allow CMC to leave medical information on my answering machine when needed.

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Signature of patient: \_\_\_\_\_ Date: \_\_\_\_\_

\* (Signature of parent or guardian if patient is a minor)