

WELCOME TO CAROLINA MEDICAL CONSULTANTS

DATE _____

NAME _____ DATE OF BIRTH _____

ADDRESS _____

Telephones: Home _____ Work _____ Cell _____

REASON FOR VISIT TODAY:

<input type="checkbox"/> Follow Up Visit	<input type="checkbox"/> *School/Sport/Work Physical	<input type="checkbox"/> **Annual Gyn Exam
<input type="checkbox"/> Yearly Follow	<input type="checkbox"/> *DOT Physical	<input type="checkbox"/> **Wellness/Preventive Exam
<input type="checkbox"/> Sick Visit	<input type="checkbox"/> *FAA Flight Physical	<input type="checkbox"/> Workers Comp Visit
		<input type="checkbox"/> Motor Vehicle Accident

***Please note these services are not covered by medical health insurance.**

****Please note, these services are preventive health exams and do not include evaluation or management of new or continuing medical conditions. You may elect to address any medical concerns at the time of this visit, but the physician is obligated to code the appropriate level of service which may result in additional fees.**

Current insurance coverage must be presented at time of service.

We will file claims with contracted insurance companies. You are expected to pay any co-payments, non-covered services or deductibles at time of service or a \$10.00 fee will be applied to your account. If your plan requires a referral, it must be presented at time of service. Patients are responsible for providing us with current insurance information. It is the patient's responsibility to determine their policy coverage.

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations:

I understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as: a) a basis for planning my care and treatment b) a means of communication among the many health professionals who contribute to my care c) a source of information for applying my diagnosis information to my bill d) a means by which a third-party payer can verify that services billed were actually provided and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I have access to and understand the Notice of Privacy Practices which provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I understand my health information may be sent to consulting physicians, including HIV/AIDS. I agree to allow this Practice to leave medical information on my answering machine when needed.

I have read and understand these policies:

Patient or responsible party signature

Date

Guardian (relationship to patient) _____