

Carolina Medical Consultants, P.A.  
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	F				
Mailing Address				City and State					Zip Code		Home Phone #			
Employer				Work Phone #					Cell 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 Coordinator 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: \_\_\_\_\_ Today's  
(Signature of parent or guardian if patient is a minor) Date: \_\_\_\_\_

Signature of guardian: \_\_\_\_\_ Date: \_\_\_\_\_  
(Relationship to patient) \_\_\_\_\_