Lowcountry Infectious Diseases, P.A.

PATIENT INFORMATION

Name
Last _____ First _____ Middle Initial ____

Address _____

City _____ State _____ Zip Code +4 _____--_____

Email Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ ☐ Male ☐ Female Social Security _____

Race ☐ American Indian/Alaskan Native ☐ Asian ☐ Black ☐ Caucasian ☐ Pacific Islander ☐ Other ☐ Decline

Ethnicity ☐ Hispanic ☐ Non Hispanic ☐ Decline Language ☐ English ☐ Spanish ☐ _____

Emergency Contact _____ Relationship _____

Home Phone _____ Cell Phone _____

Guarantor _____ Date of Birth _____ Social Security _____

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Unknown

Student Status ☐ Not student ☐ Fulltime ☐ Part time

Referring Physician _____ Primary Physician _____

Primary Insurance ☐ Yes ☐ No Insurance Company Name _____

Policy Holder Name _____ Relationship _____

Policy # _____ Group # _____ Policy Holder DOB _____

Secondary Insurance ☐ Yes ☐ No Insurance Company Name _____

We do not file Medicaid as a secondary insurance.

Policy Holder Name _____ Relationship _____

Policy # _____ Group # _____ Policy Holder DOB _____

Communication Preferences

May we contact you by mail? ☐ Yes ☐ No What is your primary phone contact? ☐ Home ☐ Work ☐ Cell

May we send text messages to your cell phone? ☐ Yes ☐ No May we contact you by email? ☐ Yes ☐ No

May we leave messages on your phone? ☐ Home ☐ Work ☐ Cell

By signing below, I certify that all of the above information is true and accurate as of the date below.

Signature _____ **Date** _____

Lowcountry Infectious Diseases, P.A.

FINANCIAL POLICY

Thank you for choosing Lowcountry Infectious Diseases, P.A. as your healthcare provider. We are committed to providing the best medical care possible. Please understand that payment for the products, procedures, and services rendered is considered a part of your treatment. The following statements explain our Financial Policy, which we ask you to read, sign, and return to us prior to your treatment.

- All patients shall provide accurate and complete personal and insurance information prior to being seen by the medical provider.
- All applicable co-payments, coinsurance, deductibles, and personal balances; both current and prior, are due at the time of service.
- We accept cash, check, money order, and credit cards, including: Visa, MasterCard, Discover, and American Express.

REGARDING INSURANCE

- All physicians are currently participating providers for most insurance companies and are considered in-network.
- We will be glad to file your primary and secondary insurance for you and accept assignment of benefits. However, we do not file Medicaid as a secondary insurance.
- In all cases we require that the guarantor, the person who is financially responsible, is personally liable for all balances not covered by insurance. *It is your responsibility to understand and comply with any predetermination of benefits or referral requirements required by your insurance company.*
- Please be aware that some of the services provided may be non-covered services under your policy and/or may not be considered medically necessary by your insurance carrier.

USUAL AND CUSTOMARY RATES

We are committed to providing the best treatment for our patients, and we charge what we believe to be reasonable and customary fees according to the complexity and thoroughness of care rendered and the skill and expertise of our specialists. If your insurance company does not agree to these usual and customary rates, you will be responsible for any balance remaining.

BILLING OFFICE

Our billing office is located in Charleston, SC. Please contact our Business Office Manager, Susan, if you have any questions or concerns regarding this policy or billing. Her phone number is 843-402-0227, option 3.

- I understand that failure to provide the correct insurance information prior to my insurance company's timely filing limit will result in the total bill being my responsibility.
- I assign all insurance benefits payable to me for services rendered directly to Lowcountry Infectious Diseases, P.A.
- I understand that I am responsible for payment of deductibles, co-payments and coinsurance at the time of each service.
- I understand that by providing my telephone numbers, I am expressly consenting to being called at those numbers by you or anyone on your behalf via manual and/or automatic dialing systems to collect on any balances.
- I understand that I am responsible for payment of services my insurance company deems medically unnecessary and/or services not covered under my insurance policy.
- I authorize the physician to release all medical information necessary for continuity of care, securing assignment of benefits and payment of balances.
- I authorize the use of this signature on all insurance submissions.
- I understand that I may request a copy of this policy for my records or review the policy on the company website at www.lowcountryid.com.
- I certify that I have read, understand and agree to this Financial Policy.

Patient Name	Patient Signature	Date

Lowcountry Infectious Diseases, P.A.

PATIENT NAME _____ DATE OF BIRTH _____

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA)
NOTICE OF PRIVACY PRACTICES (NPP)

We are required by law to maintain the privacy of and provide individuals with a notice of our legal duties and privacy practices with respect to protected health information. We offer a laminated copy attached to our patient registration clipboards and/or a framed copy on our waiting room wall. We will also provide a printed copy upon request.

By signing below, you acknowledge that you have received a HIPAA Notice of Privacy Practices to review.

PATIENT SIGNATURE _____ DATE _____

PATIENT PORTAL
ONLINE MEDICAL RECORD ACCESS AND SECURE PROVIDER COMMUNICATION

You have access to your medical record and a way to securely communicate with our staff through the Patient Portal link on the home page of our website, www.lowcountryid.com or from https://webview.mckesson.com/lcidsWebView/.

Your username is the 1st initial of your first name, 1st initial of your middle name and whole last name. For example, Jane Marie Doe would be jmdoe.

Your password is pa$$word and your date of birth (MMDDYY). For example, date of birth October 12, 1979 would be pa$$word101279. You will immediately be asked to change it the first time you log in.

☐ I wish to REFUSE access to my online medical record and secure provider communication.

COMMUNICATION DESIGNATION

Do you want to designate a family member or individual with whom we may discuss your healthcare?

By listing an individual(s) and signing below, you authorize Lowcountry Infectious Diseases to release and/or discuss your medical and financial information with the individual. (If you wish to restrict the type or dates of information or people or entities, you must fill out a separate Request for Confidential Communication/Restriction of Protected Health Information form.)

DESIGNATED INDIVIDUAL NAME _____ PHONE NUMBER _____ RELATIONSHIP _____

DESIGNATED INDIVIDUAL NAME _____ PHONE NUMBER _____ RELATIONSHIP _____

PATIENT SIGNATURE _____ DATE _____