PATIENT INFORMAT	ION P	atient's SSN		
Male Female	_ I	Email		
Patient's Name				
(Last)		(First)	(M	iddle)
Patient's Address(Street	or P.O. Box)	(City)	(State)	(Zip Code)
Phone Numbers: Home	,		· · · · · · · · · · · · · · · · · · ·	· • /
Birth Date A				
Race (Optional):	-			
Patient's Employer				
Employer's Address				
Spouse's Name	SSN	Employer		Phone #
Emergency Contact		Relat	ionship	Phone #
IF PATIENT IS A CHILD:				
Mother	SSN	Employer		Phone #
Father	SSN	Employer		Phone #
Primary Insurance:	Group		Policy #	
			*DOB	
Secondary Insurance:				
			*DOB	
*We must ha	ve the date of hirth o	f the Insurance Policy Ho	lder to file your insurance	claims

*** Please attach Insurance Card(s) and Driver's License so we can make a copy for your records.***

Please Note:

Office visits, office surgeries, non-surgical treatments, telehealth visits, and some hospital procedures are paid at the time of service unless you have a contract insurance such as Medicare, BC/BS, Cigna, Blue Choice, etc. If you are using contract insurance, you will be required to pay your co-payment and/or deductible at the time of service.

I understand that I am responsible for all charges until paid. I understand that I am responsible for obtaining prior authorization, all deductibles, co-payments, and cost shares, including deductible and co-payments.

Authorization: I authorize Drs. Ploch, Brisson and Nickles of Palmetto Adult and Children's Urology, PA to release medical information to insurance carriers and medical professionals concerning my illness or treatments. I authorize payment of medical benefits to the physicians of Palmetto Adult and Children's Urology, PA for services rendered.

Date



Financial Policy and Disclosure

The Financial Policy and Disclosure is to help us provide the most efficient and reasonable health care services. Therefore, it is necessary for us to have a Financial Policy and Disclosure stating our requirements for payment for services provided to patients.

Patients are responsible for the payment of all services provided by Palmetto Adult and Children's Urology.

Self-Pay Policy

- If you are a self-pay patient, you will be required to pay for the office visit before services are rendered.
- In addition, any remaining balance on your account will be collected at discharge.

Insurance Policy

- If you are an insurance patient, it is our policy to file for insurance as a courtesy to you, if we have accurate and complete insurance information.
- If a service is provided that is not covered by your insurance company, you will be the responsible party at the time of service.
- If we have not received a payment from your insurance company within thirty (30) days, you will be responsible for the balance due.
- Deductibles, co-payments, and coinsurance will be collected before services are rendered.
- In special cases, we may need your help in contacting your insurance company for the payment of your services.

Workers Compensation Policy

- If you are a workers compensation patient, it is our policy to bill your employer or the worker's compensation carrier for services rendered.
- If payment is denied from your worker's compensation carrier, you will become responsible for the entire balance of your services. Payment will be due within ten (10) days following any worker's compensation payment denial.
- It will be your responsibility to contact us with the name and address of your employer or the insurance company that covers your employer.

Overdue and Credit Balances

- All over-due patient balances will be sent to collections.
- All accounts sent to collections will be charged a \$25 collection fee in addition to the account balance.
- Credit balances under \$15 aged over 60 days may be written off.
- Credit balances may be returned upon request. Credit requests will be processed within 30 days after all insurance claims are paid.

Missed Appointment Fees

- You may be subject to a missed appointment fee if cancelled or no-showed within 24 hours
- The fee amount varies depending on the type of appointment and can range from \$25 \$150.

Divorce or Custody Case Policy

• The parent or guardian who brings the patient into our office will be held financially responsible, regardless of the provisions in the divorce decree, or who has custody, or who has the insurance.

To help in this policy, we ask that you assist us by:

- 1. Providing us with current and updated information on yourself and your insurance company.
- 2. Presenting an updated photo identification card and insurance card when changes are made.
- 3. Making the appropriate payment at the time of service, whether it is a deductible, copay, coinsurance, or for the full amount if you are a Self-Pay Patient.

In order to provide the best medical care, we ask that you <u>do not</u> discuss your account balance or financial aspects with the physician(s) or medical staff. Please discuss any account information with the check out associate or front desk.

Responsible Party's Signature

Date

PALMETTO ADULT AND CHILDREN'S UROLOGY, P.A.

Authorized Methods of Communication

At times, we need to communicate with you or with people that you choose regarding your health care. Therefore, you authorize Palmetto Adult and Children's Urology to communicate information regarding your health care and/or billing with:

□ Spouse		
□ Family Member	 	
□ Friend		

I GIVE PERMISSION FOR PALMETTO ADULT AND CHILDREN'S UROLOGY TO USE THE PHONE NUMBERS THAT I HAVE PROVIDED FOR THE PURPOSE OF CONTACTING ME AND FOR LEAVING A MESSAGE.

Palmetto Adult and Children's Urology is required to abide by the terms outlined in this notice. However, Palmetto Adult and Children's Urology reserves the right to change the terms of this Privacy Notice and make the new provisions effective for all protected health information that we maintain. Any revisions of this notice will be posted and distributed during office appointments.

If you have any questions regarding permitted uses or disclosures of your protected health information or if you have questions regarding the Notice of Privacy Practices, please contact the Office Manager at (843) 797-6600.

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name

(Print)

Patient/Guardian Signature

Date

Birth Date

Witness

Date

** Copy of the Notice of Privacy Practices available at www.palmettourology.com **

Chart Number _____

Revised 02/2019



Palmetto Adult and Children's Urology

2890 Tricom Street North Charleston, SC 29406 Telephone: 843/797-6600 Fax: 843/820-1440 104-C Morgan Place Summerville, SC 29485 Telephone: 843/879-9163 Fax: 843/879-9952

302 Medical Park, Ste 207 Walterboro, SC 29488 Telephone: 843/549-7122 Fax: 843/549-3257

Nelson R. Ploch, MD Theodore E. Brisson, MD S. Walker Nickles, MD Georgia Anderson, PA-C

Advanced Directives Form

Do you have a Power of Attorney? Yes No

What are your resuscitation preferences?

- a. I do not wish to be resuscitated under any circumstance
- b. I wish to be resuscitated unless I am brain dead or have no quality of life
- c. I wish to always be resuscitated, regardless of circumstance

Do you have a Medical Power of Attorney? Yes No

I wish to disclose this information? Yes No

NEW PATIENT CLINICAL INFORMATION

NAME:	Н	lt: Wgt:
PLEASE LIST YOUR PRIMARY CARE DOCTOR:		
PLEASE LIST YOUR PHARMACY AND PHONE NUMBE		
PLEASE LIST OTHER PHYSICIANS THAT ARE CURREN	VTLY TREATING YOU:	
PLEASE LIST ALL MEDICATIONS AND EYE DROPS YO	OU ARE CURRENTLY TAP	KING:
DI EASE LIST ANY DDUG ALLEDGIES.		
PLEASE LIST ANY DRUG ALLERGIES: PLEASE LIST ANY FOOD ALLERGIES:		
HAVE YOU RECEIVED A FLU SHOT THIS YEAR?		
IF YES, WHEN? (date)IF NO, WHY?		
PLEASE LIST ANY SURGERIES YOU HAVE HAD, ALON		
OTHER THAN SURGERIES, PLEASE LIST ANY TREAT	MENTS OR HOSPITILIZAT	TIONS, WITH
DATES, THAT YOU HAVE HAD:		
PLEASE LIST YOUR KNOWN MEDICAL PROBLEMS: (E	X: HIGH BLOOD PRESSURE, DIAB	ETES, ETC)
CHILDHOOD:		
ADULTHOOD:		
PLEASE LIST ANY ILLNESSES YOUR BLOOD RELATIV		
FATHER:		
MOTHER:		
BROTHER/SISTER:		
AUNT/UNCLE:		
GRANDPARENTS:		
IF YOU SMOKE, HOW MANY PACKS PER DAY:	YEARS SMOKED:	
DO YOU SMOKE CIGARS: YES / NO CHEW TOBACC		
IF YOU DRINK ALCOHOL, WHAT DO YOU DRINK ANI		'F: 1E5/ NO
MARITAL STATUS: SINGLE MARRIED WIDO		
NUMBER OF CHILDREN:AGES:		
REASON FOR DOCTOR'S APPOINTMENT TODAY:		
SIGNATURE:	DATE	

REVIEW OF SYSTEMS

DO YOU HAVE ANY OF THE FOLLOWING TODAY? CIRCLE YES OR NO.

NAME: _____

FEVER YES NO JOINT PAIN YES NO CHILLS YES NO NECK PAIN YES NO WEIGHT LOSS YES NO NECK PAIN YES NO OTHER: OTHER: OTHER: NEUROLOGICAL NEUROLOGICAL BLURRED VISION YES NO DIZZY SPELLS YES NO OUBLE VISION YES NO DIZZY SPELLS YES NO OTHER: OTHER: OTHER: YES NO OTHER: YES NO DEPRESSED YES NO OTHER: OTHER: YES NO NO NO SINUS PROBLEMS YES NO ANXIOUS YES NO SINUS PROBLEMS YES NO OTHER: NO NO OTHER: OTHER: Itematologic/Lymphatic YES NO CARDIOVASCULAR HEMATOLOGIC/LYMPHATIC YES NO NO OTHER: OTHER: OTHER: NO NO OTHER: OTHER: OTHER: NO NO OTHER: OTHER: NO BLOOD CLOTING PROBLEM YES NO OTHER: OTHER: OTH	CONSTITUTIONAL SYMPTOMS			MUSCULOSKELETAL		
WEIGHT LOSS YES NO BACK PAIN YES NO OTHER: OTHER: OTHER: OTHER: OTHER: NO EYES NO TREMORS YES NO DOUBLE VISION YES NO DIZZY SPELIS YES NO OTHER: OTHER: OTHER: YES NO NUMBNESS/TINGLING YES NO OTHER: OTHER: OTHER: OTHER: NO NUMBNESS/TINGLING YES NO EARS/NOSE/ THROAT/ MOUTH FAR INFECTION YES NO DEPRESSED YES NO SINUS PROBLEMS YES NO OTHER: OTHER: NO NO OTHER: YES NO OTHER: NO NO NO OTHER: YES NO OTHER: NO NO OTHER: YES NO OTHER: NO NO OTHER: YES NO OTHER: NO NO OTHER: OTHER: CARDIOVASCULAR YES NO BLOOD CLOTING PROBLEM YES NO PALPITATIONS YES NO BLOOD CLOTING PROBLEM YES NO SORENTINES NO OTHER:	FEVER	YES	NO		YES	NO
WEIGHT LOSS YES NO BACK PAIN YES NO OTHER: OTHER: OTHER: OTHER: OTHER: NO EYES NO TREMORS YES NO DOUBLE VISION YES NO DIZZY SPELIS YES NO OTHER: OTHER: OTHER: YES NO NUMBNESS/TINGLING YES NO OTHER: OTHER: OTHER: OTHER: NO NUMBNESS/TINGLING YES NO EARS/NOSE/ THROAT/ MOUTH FAR INFECTION YES NO DEPRESSED YES NO SINUS PROBLEMS YES NO OTHER: OTHER: NO NO OTHER: YES NO OTHER: NO NO NO OTHER: YES NO OTHER: NO NO OTHER: YES NO OTHER: NO NO OTHER: YES NO OTHER: NO NO OTHER: OTHER: CARDIOVASCULAR YES NO BLOOD CLOTING PROBLEM YES NO PALPITATIONS YES NO BLOOD CLOTING PROBLEM YES NO SORENTINES NO OTHER:	CHILLS	YES	NO	NECK PAIN	YES	NO
OTHER: OTHER: OTHER: EVES NEUROLOGICAL BLURRED VISION YES NO DOUBLE VISION YES NO OTHER: OTHER: NO EARS/NOSE/THROAT/MOUTH PSYCHOLOGICAL EARINFECTION YES NO SORE THROAT YES NO SINUS PROBLEMS YES NO OTHER: OTHER: NO OTHER: NO PAIN'OUTH CHEST PAIN YES NO PALPITATIONS YES NO PALPITATIONS YES NO BLOOD CLOTTING PROBLEM YES NO OTHER: OTHER: NO PALPITATIONS YES NO PALPITATIONS YES NO BLOOD CLOTTING PROBLEM YES NO OTHER: OTHER: NO SHORTNESS OF BREATH YES NO PADOMINAL PAIN <td></td> <td></td> <td>NO</td> <td></td> <td>YES</td> <td>NO</td>			NO		YES	NO
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OTHER:	DOUBLE VISION	YES	NO	DIZZY SPELLS	YES	NO
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SINUS PROBLEMS YES NO OTHER:						
OTHER:					YES	NO
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GASTROINTESTINALINTEGUMENT/SKINABDOMINAL PAINYESNOBLOODY OR DARK TARRY STOOLYESNOPERSISTANT ITCHYESNODIARRHEAYESNODISCHARGEYESNOYESNOBOILSCONSTINARYYESNOPERSISTANT ITCHYESYESNOBOILSYESCONSTIPATIONYESYESNOPERSISTANT SCARRINGYESYESNOPERSISTANT SCARRINGYESYESNOYESNOYESNOYESNOYESNOYESNOYESNOYESNOYESNOYESNOYESNOYESNOYESNO	SHORTNESS OF BREATH	YES	NO	TIRED/SLUGGISH	YES	NO
ABDOMINAL PAINYESNORASHYESNOBLOODY OR DARK TARRY STOOLYESNOPERSISTANT ITCHYESNODIARRHEAYESNOBOILSYESNOCONSTIPATIONYESNOEXCESSIVE SCARRINGYESNOOTHER:OTHER:GENITOURINARYYESNOALLERGY/IMMUNE SYSTEMYESNO	OTHER:			OTHER:		
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BLOODY OR DARK TARRY STOOL YES NO PERSISTANT ITCH YES NO DIARRHEA YES NO BOILS YES NO CONSTIPATION YES NO EXCESSIVE SCARRING YES NO OTHER:						
DIARRHEA YES NO BOILS YES NO CONSTIPATION YES NO EXCESSIVE SCARRING YES NO OTHER:						
CONSTIPATION YES NO EXCESSIVE SCARRING YES NO OTHER:						
OTHER: OTHER						
GENITOURINARY ALLERGY/IMMUNE SYSTEM DISCHARGE YES NO		YES	NO		YES	NO
DISCHARGE YES NO FOOD ALLERGY YES NO	OTHER:			OTHER:		
DISCHARGE YES NO FOOD ALLERGY YES NO	GENITOURINARY			ALLERGY/IMMUNE SYSTEM		
		YES	NO		YES	NO
	PAIN WITH URINATION	YES	NO	HAY FEVER	YES	NO
FREQUENCY OF URINATION YES NO HIV YES NO	FREQUENCY OF URINATION	YES	NO	HIV	YES	NO
OTHER: OTHER:	OTHER:			OTHER:		