PATIENT INFORMATION

Patient's SSN _____

Male ☐ Female ☐ Email _____

Patient's Name _____
(Last) (First) (Middle)

Patient's Address _____
(Street or P.O. Box) (City) (State) (Zip Code)

Phone Numbers: Home _____ Work _____ Cell _____

Birth Date _____ Age _____ Referring and/or Family Physician _____

Race (Optional):_____ Ethnicity (Optional): ☐ Hispanic ☐ Non-Hispanic Preferred Language: _____

Patient's Employer _____

Employer's Address _____

Spouse's Name _____ SSN _____ Employer _____ Phone # _____

Emergency Contact_____ Relationship_____ Phone # _____

IF PATIENT IS A CHILD:

Mother _____ SSN _____ Employer _____ Phone # _____

Father _____ SSN _____ Employer _____ Phone # _____

Primary Insurance:_____ Group_____ Policy # _____

Policy Holder Name _____ SSN _____ *DOB _____

Secondary Insurance: _____ Group _____ Policy # _____

Policy Holder Name _____ SSN _____ *DOB _____

**We must have the date of birth of the Insurance Policy Holder 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, Nickles, and Vaughan and Grace Howie, PA-C 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.

Patient's Signature_____ Date _____
(Parent or Guardian if patient is a minor)

Revised 08/2021

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 do not 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 _____

Printed Patient Name _____ DOB _____

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 _____ Birth Date _____
(Print)

_____ _____
Signature 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:_____Ht:_____Wgt:_____
PLEASE LIST YOUR PRIMARY CARE DOCTOR: _____
PLEASE LIST YOUR PHARMACY AND PHONE NUMBER: _____
PLEASE LIST OTHER PHYSICIANS THAT ARE CURRENTLY TREATING YOU:

_____
PLEASE LIST ALL MEDICATIONS AND EYE DROPS YOU ARE CURRENTLY TAKING:

_____
_____
_____
_____
PLEASE LIST ANY DRUG ALLERGIES: _____
PLEASE LIST ANY FOOD ALLERGIES: _____
HAVE YOU RECEIVED A FLU SHOT THIS YEAR? ☐ YES ☐ NO
IF YES, WHEN? (date)_____IF NO, WHY?_____
PLEASE LIST ANY SURGERIES YOU HAVE HAD, ALONG WITH THEIR DATES:

_____
_____
_____
OTHER THAN SURGERIES, PLEASE LIST ANY TREATMENTS OR HOSPITILIZATIONS, WITH DATES, THAT YOU HAVE HAD:

_____
_____
_____
PLEASE LIST YOUR KNOWN MEDICAL PROBLEMS: (EX: HIGH BLOOD PRESSURE, DIABETES, ETC)
CHILDHOOD: _____
_____
ADULTHOOD: _____
_____
PLEASE LIST ANY ILLNESSES YOUR BLOOD RELATIVES HAVE HAD:
FATHER:_____
MOTHER:_____
BROTHER/SISTER:_____
AUNT/UNCLE:_____
GRANDPARENTS: _____

IF YOU SMOKE, HOW MANY PACKS PER DAY:_____YEARS SMOKED: _____
DO YOU SMOKE CIGARS: YES☐NO☐CHEW TOBACCO: YES☐NO☐USE SNUFF: YES☐NO☐
IF YOU DRINK ALCOHOL, WHAT DO YOU DRINK AND HOW OFTEN:

_____
MARITAL STATUS: SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED ☐
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: _____

CONSTITUTIONAL SYMPTOMS
FEVER YES NO
CHILLS YES NO
WEIGHT LOSS YES NO
OTHER: _____

EYES
BLURRED VISION YES NO
DOUBLE VISION YES NO
PAIN YES NO
OTHER: _____

EARS/ NOSE/ THROAT/ MOUTH
EAR INFECTION YES NO
SORE THROAT YES NO
SINUS PROBLEMS YES NO
OTHER: _____

CARDIOVASCULAR
CHEST PAIN YES NO
PALPITATIONS YES NO
OTHER: _____

RESPIRATORY
WHEEZING YES NO
COUGH YES NO
SHORTNESS OF BREATH YES NO
OTHER: _____

GASTROINTESTINAL
ABDOMINAL PAIN YES NO
BLOODY OR DARK TARRY STOOL YES NO
DIARRHEA YES NO
CONSTIPATION YES NO
OTHER: _____

GENITOURINARY
DISCHARGE YES NO
PAIN WITH URINATION YES NO
FREQUENCY OF URINATION YES NO
OTHER: _____

MUSCULOSKELETAL
JOINT PAIN YES NO
NECK PAIN YES NO
BACK PAIN YES NO
OTHER: _____

NEUROLOGICAL
TREMORS YES NO
DIZZY SPELLS YES NO
NUMBNESS/TINGLING YES NO
OTHER: _____

PSYCHOLOGICAL
DEPRESSED YES NO
ANXIOUS YES NO
OTHER: _____

HEMATOLOGIC/LYMPHATIC
LYMPH NODE PAIN/ SWELLING YES NO
BLOOD CLOTTING PROBLEM YES NO
OTHER: _____

ENDOCRINE
HEAT/COLD INTOLERANCE YES NO
EXCESSIVE THIRST YES NO
TIRED/SLUGGISH YES NO
OTHER: _____

INTEGUMENT/SKIN
RASH YES NO
PERSISTANT ITCH YES NO
BOILS YES NO
EXCESSIVE SCARRING YES NO
OTHER: _____

ALLERGY/IMMUNE SYSTEM
FOOD ALLERGY YES NO
HAY FEVER YES NO
HIV YES NO
OTHER: _____

SIGNATURE: _____ DATE: _____

Revised 04/2020