

PATIENT INFORMATION

Account	Social Security #	Title	Patient Last Name	First Name	M.I.
Street Address		City	State	Zip	Home Phone
Mailing Address		City	State	Zip	Cell Phone
Date of Birth	Sex <input type="radio"/> M <input type="radio"/> F	Race <input type="radio"/> Black <input type="radio"/> White <input type="radio"/> Hispanic <input type="radio"/> Other		Marital Status <input type="radio"/> S-Single <input type="radio"/> M-Married <input type="radio"/> D-Divorced <input type="radio"/> W-Widowed <input type="radio"/> X-Separated	
Employment <input type="radio"/> R-Retired <input type="radio"/> F-Full <input type="radio"/> P-Part <input type="radio"/> N-None	Student <input type="radio"/> F-Full <input type="radio"/> P-Part <input type="radio"/> N-None	Rel. to Insured <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other			Referring Physician
Email				Primary Care Physician	
Employer	Street Address	City	State	Zip	Work Phone

FINANCIALLY RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

Relationship <input type="radio"/> Spouse <input type="radio"/> Parent <input type="radio"/> Legal Guardian	Social Security #	Last Name	First	M.I.	
Street Address (If different than above)		City	State	Zip	Home Phone
Date of Birth	Sex <input type="radio"/> M <input type="radio"/> F	Race <input type="radio"/> Black <input type="radio"/> White <input type="radio"/> Hispanic <input type="radio"/> Other		Rel. to Insured <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other	
Employer	Street Address	City	State	Zip	Work Phone

INSURANCE INFORMATION

Primary Insurance Carrier			Policy Number			Group Number		
Insured's Last Name		First Name		M.I.	Date of Birth		Social Security #	
Employer	Street Address		City	State	Zip	Work Phone		
Secondary Insurance Carrier			Policy Number			Group Number		
Insured's Last Name		First Name		M.I.	Date of Birth		Social Security #	
Employer	Street Address		City	State	Zip	Work Phone		

BILLING AUTHORIZATION

I authorize the release of any medical information necessary to process health insurance claims.
 I request payment of benefits to be made directly to RMC Women's Center.
 I understand that any unpaid balances will be billed to me and are due in full within 90 days of notification from this office.
 In addition, I agree that I will be responsible for any collection fees and understand unpaid palaces may be filed with the State Tax Set Off Program.

I have read, understand, and agree to all of the above.

This authorization is valid unless rescinded in writing. A photocopy is as valid as the original.

RMC Women's Center is a Regional Medical Center Practice and all staff and physicians are Regional Medical Center employees.

Patient Signature	Date
Legal Guardian Signature	Date
Emergency Contact	Phone



Women's Center

a Department of Regional Medical Center

2850 Pelham Court
Orangeburg, SC 29118
Phone: 803-395-3737
Fax: 803-531-0133

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____

- My protected health information is NOT to be discussed.
- My protected health information may be discussed with the following person(s):

	<u>NAME</u>	<u>RELATIONSHIP</u>	<u>PHONE NUMBER</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Patient Signature: _____ **Date:** _____

CONSENT TO MEDICAL TREATMENT

I, suffering from a condition requiring medical/surgical services, hereby consent to the rendering of such care. Medical/surgical treatment may include routine diagnostic procedures and such medical treatment as the attending physician(s) is authorized to perform by the State of South Carolina.

Patient Signature: _____ **Date:** _____

- If the patient is a minor, the signature of a parent or guardian is required.
- If the patient is unable to sign for him/herself, the patient should mark an "X." RMC Women's Center staff will write "Mark of" (patient's name) and two staff members will witness the mark.
- If anyone other than the patient is signing, we need the patient's name and the name of the signing adult with the relationship.

ASSIGNMENT OF MEDICARE AND/OR MEDICAID BENEFITS

I hereby assign all medical and/or surgical benefits to which I am entitled to RMC Women's Center including Medicare and Medicaid.

Medicare patients will be asked to review and sign an Advance Beneficiary Notice (ABN) for all services, which may be deemed not medically necessary.

Signature of Insured

Date

ASSIGNMENT OF BENEFITS

I hereby assign all medical and /or surgical benefits to which I am entitled to RMC Women's Center, including private insurance and any/all other third party coverage.

If we do not participate with your insurance plan, we request that your charges for office visits be paid at the end of each visit.

Signature of Insured

Date

PAYMENT GUARANTEE

The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, the undersigned individually obligates himself/herself to pay the account of RMC Women's Center in accordance with the regular rates and terms of the practice. Furthermore, the undersigned is obligated to make weekly or monthly payments, if requested. Should the account be turned over to a collection agency or an attorney for collection, the undersigned shall pay all collection fees and reasonable attorney's fees.

I understand that I am responsible to RMC Women's Center for charges incurred by me and not paid for by Medicare, Medicaid, or third party benefits.

INSURANCE COLLECTIONS

In order for RMC Women's Center to file your insurance for you, a copy of your insurance card (front and back) is required.

RMC Women's Center will submit the standard CMS 1500 billing form to your insurer. If your employer/ insurance carrier requires other claim forms, these must be submitted completely filled out, and signed. (You are always responsible for the entire amount of the charges.) All applicable coinsurance and deductibles are due upon Check Out.

I acknowledge that I have read or had read to me the entire above document. I understand it and I agree that RMC Women's Center may bill me and that I will pay for non-covered services or services determined to be not medically necessary.

Signature of Insured

Date