+rmc Obstetrics & Gynecology
a Department of the Regional Medical Center

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	Race	Marital Status
	❍ M ❍ F	❍ Black ❍ White ❍ Hispanic ❍ Other	❍ S-Single ❍ M-Married ❍ D-Divorced ❍ W-Widowed ❍ X-Separated

Employment	Student	Rel. to Insured	Referring Physician
❍ R-Retired ❍ F-Full ❍ P-Part ❍ N-None	❍ F-Full ❍ P-Part ❍ N-None	❍ Self ❍ Spouse ❍ Child ❍ Other	

Email	Primary Care Physician

Employer	Street Address	City	State	Zip	Work Phone

FINANCIALLY RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

Relationship	Social Security #	Last Name	First	M.I.
❍ Spouse ❍ Parent ❍ Legal Guardian				

Street Address (If different than above)	City	State	Zip	Home Phone

Date of Birth	Sex	Race	Rel. to Insured
	❍ M ❍ F	❍ Black ❍ White ❍ Hispanic ❍ Other	❍ Self ❍ Spouse ❍ Child ❍ 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 Obstetrics & Gynecology.
- 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This authorization is valid unless rescinded in writing.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 Obstetrics & Gynecology 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**

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1175 Cook Road, Suite 145
Orangeburg, SC 29118-8201
Phone: 803-531-2300
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):

	NAME	RELATIONSHIP	PHONE NUMBER
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 Obstetrics & Gynecology 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.

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ASSIGNMENT OF MEDICARE AND/OR MEDICAID BENEFITS

I hereby assign all medical and/or surgical benefits to which I am entitled to RMC Obstetrics & Gynecology 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 Obstetrics & Gynecology, 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 Obstetrics & Gynecology in accordance with the regular rates and terms of the practice. Furthermore, the undersigned is obligated to make weekly or monthly payments, if requested. She 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 Obstetrics & Gynecology for charges incurred by me and not paid for by Medicare, Medicaid, or third party benefits.

INSURANCE COLLECTIONS

In order for RMC Obstetrics & Gynecology to file your insurance for you, a copy of your insurance card (front and back) is required.

RMC Obstetrics & Gynecology 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 Obstetrics & Gynecology may bill me and that I will pay for non-covered services or services determined to be not medically necessary.

Signature of Insured **Date**