Carolina Concierge Care

244 Church Street, Sumter, SC 29150

(803)775-1001 Fax: (803)774-1012

Date: ____________________

PATIENT INFORMATION:

LEGAL NAME____

ADDRESS____

CITY _________________________________ STATE _______________ ZIP CODE __________________

HOME PHONE _______________________________ CELL PHONE _______________________________

WORK PHONE _______________________________ SEX: ☐ MALE ☐ FEMALE

SOCIAL SECURITY NUMBER _______________________________ DATE OF BIRTH __________________

MARITAL STATUS: SINGLE/MARRIED/WIDOWED/DIVORCED/SEPARATED

E-Mail: ____

Preferred Language: ☐ English ☐ Spanish ☐ other ________________

Race: ☐ African American ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ American Indian or Alaska Native

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

EMERGENCY CONTACT:

First contact

NAME_ ____ RELATIONSHIP ___________________

Home # ______________________ Cell # _____________________ Work # _______________________

Second contact:

NAME_ ____ RELATIONSHIP ____________________

Home # _____________________ Cell # ______________________ Work # _______________________

INSURANCE INFORMATION: (PLEASE PROVIDE A COPY TO RECEPTIONIST FOR OUR RECORDS)

PRIMARY INSURANCE: ______________________________________ ID # ____________________________

Policy Holder Name ______________________________________ Policy Holder DOB ___________________

Policy Holder SSN ____

SECONDARY INSURANCE: ______________________________________ ID# ___________________________

Policy Holder Name ____ Policy Holder DOB ________________

Policy Holder SSN ____

THIRD INSURANCE: ____ ID # ____________________________

Policy Holder Name ____ Policy Holder DOB ________________

Policy Holder SSN ____

***RESPONSIBLE PARTY: (IF OTHER THAN SELF PLEASE PROVIDE FOLLOWING INFORMATION)**

GUARANTOR NAME: ____ RELATIONSHIP ________________

ADDRESS: ____

CITY __________________________________ STATE ____________ ZIP CODE __________________________

HOME # __________________________ CELL # ________________________ WORK # ___________________

ANY/ALL COPAYS ARE DUE AT THE TIME OF SERVICE

I HEREBY AUTHORIZE ANY BENEFITS FOR ALL MEDICAL CLAIMS PERTAINING TO CAROLINA CONCIERGE CARE TO BE MADE PAYABLE TO CAROLINA CONCIERGE CARE. A PHOTOCOPY OF THIS AGREEMENT IS TO BE CONSIDERED VALID AS AN ORIGINAL. I UNDERSTAND I HAVE THE RIGHT TO REQUEST A RESTRICTION AS TO HOW MY PROTECTED INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS OF THE PRACTICE. CAROLINA CONCIERGE CARE IS NOT REQUIRED TO AGREE TO THE RESTRICTIONS THAT I MAY REQUEST. I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS CONSENT, IN WRITING, AT ANY TIME, EXCEPT TO THE EXTENT THAT CAROLINA CONCIERGE CARE HAS TAKEN ACTION IN RELIANCE ON THIS CONSENT. I ALSO UNDERSTAND I HAVE THE RIGHT TO REVIEW CAROLINA CONCIERGE CARE NOTICE OF PRIVACY PRACTICES PRIOR TO SIGNING THIS DOCUMENT. I UNDERSTAND THAT CAROLINA CONCIERGE CARE HAS THE RIGHT TO CHANGE THE PRIVACY PRACTICES THAT ARE DESCRIBED IN THE NOTICE OF PRIVACY PRACTICES. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL SERVICES RENDERED TO ME AND I MAY BE CHARGED FOR ANY APPOINTMENT THAT IS NOT CANCELLED BEFORE THE TIME OF THE APPOINTMENT. I HEREBY AUTHORIZE THAT THE ABOVE INFORMATION IS CORRECT.

PATIENT SIGNATURE/RESPONSIBLE PARTY ____

RELATIONSHIP IF NOT SELF __________________________________ DATE ___________________________