Thank you for choosing Pee Dee Surgical Group for your surgical needs. We stand ready to serve you. We encourage you to print these forms and fill these out at your convenience before coming into our office. Please bring these forms and your medications with you to your visit. We thank you and appreciate you giving us the opportunity to be a part of your surgical healthcare. Any questions, please call us at (843) 665-7941.

We respectfully thank you,

Staff of Pee Dee Surgical Group

McLeod Physician Associates

Date: ___/___/___

Patient Information

Patient Last Name:	Patient First Name:	Middle Initial:
Mailing Address:	City:	State/Zip Code:
Home Phone #:	Mobile Phone #:	Work Phone #:
Date of Birth: (mm/dd/yyyy)	Gender: ☐Male ☐Female ☐Transgender	Marital Status: ☐Married ☐Partner ☐Separated ☐Single ☐Divorced ☐Widowed
Social Security #:	Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino	

Race : ☐Hawaiian ☐Pacific Islander ☐White ☐Black or African American ☐Hispanic ☐Other

Language: ☐English ☐Indian (Includes Hindi and Tamil) ☐Spanish ☐Russian ☐Other

Email Address: «Email»

Patient Employer Information

Employer Name:	Employer Phone #:

Employer Address: «EmployerAddress»

Guarantor/Card Holder Information

☐Same as above.

Guarantor Last Name:	Guarantor First Name:	Middle Initial:
Mailing Address:	City:	State/Zip Code:
Social Security #:	Date of Birth: (mm/dd/yyyy)	Gender: ☐Male ☐Female
Home Phone #: ( )	Mobile Phone #: ( )	Relationship to Patient: ☐Parent ☐Spouse ☐Other
Guarantor's Employer Name:	Guarantor's Employer Phone: ( )	

Guarantor's Employer Address:

Insurance Information

Primary Insurance Name:	Group ID#:	CoPay:	Member ID#:
Subscriber's Name :	Relationship to Subscriber: ☐Self ☐Parent ☐Other		Subscriber's SSN: - -
Subscriber's Address:	Subscriber's City:		Subscriber's State/Zip Code:
Secondary Insurance Name:	Group ID#:	CoPay:	Member ID#:
SubScriber's Name :	Relationship to Subscriber: ☐Self ☐Parent ☐Other		Subscriber's SSN: - -
Subscriber's Address:	Subscriber's City:		Subscriber's State/Zip Code:

Emergency Contact

Emergency Contact Name:	Contact Phone #:	Work Phone #: ( )

Preferred Pharmacy

Pharmacy Name:	Pharmacy Address:

PERSONAL MEDICAL HISTORY
Please complete below

DATE: _____ AGE: _____

NAME: _____

FAMILY PHYSICIAN: _____
FIRST NAME LAST NAME CITY

REFERRING PHYSICIAN: _____
FIRST NAME LAST NAME CITY

COMPLAINT/PROBLEM: _____

DRUG ALLERGIES: _____

CURRENT MEDICATIONS: _____

_____

SURGERY/OPERATIONS: _____

_____

SOCIAL HISTORY:

OCCUPATION: _____ ALCOHOL: _____ HOW MUCH? _____
HOBBIES: _____ TOBACCO: _____ HOW MUCH? _____
MARITAL STATUS: _____ RELIGION: _____
Do you have a Living Will? Yes _____ No _____

PATIENT PERSONAL PAST MEDICAL HISTORY / REVIEW OF SYSTEMS:

Diabetes	**Yes _____No _____**	**GI Disorder**	**Yes _____No _____**
Tuberculosis	**Yes _____No _____**	**GU disorder**	**Yes _____No _____**
Rheumatic Fever	**Yes _____No _____**	**Menstrual Problems**	**Yes _____No _____**
Hepatitis	**Yes _____No _____**	**Vascular Disease**	**Yes _____No _____**
Seizures	**Yes _____No _____**	**Extremity Problems**	**Yes _____No _____**
Hypertension	**Yes _____No _____**	**Bleeding Problems**	**Yes _____No _____**
Heart Disease	**Yes _____No _____**	**Cancer**	**Yes _____No _____**
Cong. Heart Failure	**Yes _____No ____**	**Blood Transfusion**	**Yes _____No _____**
Strokes	**Yes _____No ____**	**Thyroid Disorder**	**Yes _____No _____**
Emphysema/Asthma	**Yes _____No ___**	**Vision Problems**	**Yes _____No _____**
Bronchitis	**Yes _____No _____**	**Fever/Chills/Wt.Chngs**	**Yes _____No _____**
Neck/Back Pain	**Yes _____No ____**	**Difficulty Swallowing**	**Yes _____No _____**
Depression/Anxiety	**Yes _____No ____**	**Skin Changes**	**Yes _____No _____**
		Breast Changes	**Yes _____No _____**

FAMILY HISTORY: (PARENTS, GRANDPARENTS, AUNTS, UNCLES, SIBLINGS)

Heart Disease	**Yes _____No____**	**Diabetes**	**Yes _____No _____**
Strokes	**Yes _____No ___**	**Tuberculosis**	**Yes _____No _____**
Hypertension	**Yes _____No ___**	**Blood Disorders**	**Yes _____No _____**
Cancer	**Yes _____No ___**	**Other**	**Yes _____No _____**

Doctor Signature_____ Date: _____

Designation of Care Givers for Communication of Protected Health Information

For the following patient: Current Date: ____/____/____

Patient Name:_____ Date of Birth: ____/____/____

Account #; _____ Chart #: _____

At my request, I authorize the person(s) listed below to inquire about my personal health and/or billing information on my behalf. In case of a minor child, this Person(s) may inquire about the child's personal health and/or billing information and, if necessary, bring the child to appointments on my behalf.

Name	Relationship	Date of Birth	Phone Number(s)
Name	Relationship	Date of Birth	Phone Number(s)
Name	Relationship	Date of Birth	Phone Number(s)

OR

_____(init) I do not want any of my personal or financial information to be given to anyone other than myself and my physicians.

At my request, I authorize Pee Dee Surgical Group to communicate my protected health information to me via the following methods:

- ☐ Leave detailed message on my home answering machine (Phone#_____)
- ☐ Leave message with call-back number only.
- ☐ Leave detailed message on my voice mail at work (Phone# _____)
- ☐ Leave detailed message on my cell phone voice mail (Phone# _____)
- ☐ Fax detailed medical information (fax# _____)
- ☐ E-mail detailed medical information (e-mail: _____)
- ☐ OK to mail to my home address
- ☐ OK to mail to my work address

Who would you like us to notify in case of an emergency?

_____

Name Relationship Date of Birth Phone Number(s)

I understand that my health care providers will use judgment in determining the minimum amount of information that must be shared in order to care for me.

Pee Dee Surgical Group will make a diligent "good faith" effort to determine the identity of the requestor before release of my personal health and/or billing information by verifying the address, date of birth and phone number for the authorized representatives I have designated. Pee Dee Surgical Group is not liable for any misuse of my personal health or billing information by the representative(s) authorized (listed) above. I understand this authorization will remain in effect unless otherwise notified and/or revoked.

_____ _____

Authorized Patient or Guarantor Signature Date

_____

Print Name

I understand that I may cancel this authorization at any time by signing this notice below. However, if I cancel this authorization, I also understand that the cancellation will **not** affect any action Pee Dee Surgical Group took in reliance on this authorization before receipt of written notice of cancellation.

Signature Authorizing Cancellation: _____

Date Authorization Cancelled: ____/____/____

MCLEOD PHYSICIAN ASSOCIATES

PATIENT CONSENT FOR TREATMENT, SERVICES AND PAYMENT

Consent for Treatment and Services: I/we hereby give my consent for treatment and related services considered necessary by McLeod Physician Associates ("MPA") for the patient whose name appears below who is seeking or is under the care of the applicable MPA physician, his/her associates, partners, assistants, employees or designees. I/we hereby understand that such treatment, may include, but is not limited to, necessary examination and/or assessment, laboratory, diagnostic and/or medical care and procedures; prescribed medical information, if available; and/or recordings and/or filming for internal purposes, which the MPA physician, his associates, partners, assistants, or designees may deem necessary or advisable. I/we understand that if medical treatment of an urgent nature is necessary for the patient named below, MPA physicians, his/her associates, partners, assistants, employees, providers, or designees will perform such laboratory, diagnostic and/or medical care and procedures.

Assignment of Insurance Benefits and Third Party Claims: I/we hereby authorize payment directly to MPA of medical benefits otherwise payable to me, including major medical insurance benefits, PIP benefits, sick benefits, or injury benefits due because of any insurance policy and the proceeds of all claims resulting from the liability of the third party payable by any person, employer or insurance company to or for the patient unless I/we pay the account in full upon the receipt of services. I/we also authorize payment of surgical, or medical, including major medical benefits, directly to MPA physicians, but not to exceed charges for these services. I/we also authorize payment of medical benefits otherwise payable to me for professional services performed by Laboratory Corporation of America ("LabCorp"), Pee Dee Pathology, PA and/or any other designated service provider or physician on the active medical staff of McLeod Health and/or MPA. I/we understand that I/we am financially responsible to MPA physicians and all providers of service for charges incurred, whether or not covered by this assignment. I/we understand that should the account be referred to an attorney for collection, I/we shall pay all reasonable attorney's fees and collection expenses. All delinquent accounts may bear interest at the legal rate. I/we further agree that in the event medical benefits exceed charges for services in connection with this episode of care, that any such excess amount be first applied to the payment of any other indebtedness due by me for treatment and services rendered or any for amount for which I/we am responsible on account of other episodes of care or services received from MPA, and the balance, if any remains, to be paid to me. I/we further authorize refund of overpaid insurance benefits in accordance with my policy conditions where my coverage is subject to the coordination of benefits clause. I/we further agree that MPA is authorized to act in my behalf in the endorsement of benefit checks made payable to me and/or MPA. If I/we am a participant /beneficiary of an employee welfare plan governed by the Employee Retirement Income Security Act of 1974 (ERISA) , 29 U.S.C. § 1001 et seq, I/we designate MPA as my authorized representative and grant to MPA to act on my behalf in pursuing and appealing a benefit determination under the plan. Such authority shall include the right to request and receive a copy of the plan description and/or summary plan description.

Medicare-Medicaid's Patient's Certification: Payment Request: I/we assign payment for the unpaid charges for certain physician services furnished by specialists and physicians for whom MPA is authorized to bill. I/we understand that I/we am responsible for any health insurance deductibles and co-insurance. I certify that the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act is correct. I/we request that payment of authorized benefits be made on my behalf.

Payment Guarantee: I/we hereby jointly and severely agree to pay all charges for services received by the patient named below during this "episode of care" and/or subsequent visits.

Follow-Up/New Episodes of Care: I/we understand that the patient named below may come in for subsequent episodes of care following his/her initial visit to MPA. I/we understand that the patient named below may receive subsequent care and/or treatment related to such episodes of care. I hereby acknowledge that I/he/she will not be required to complete a subsequent registration form containing all of the information stated within this Patient Consent for Treatment, Services, and Payment but agree to be bound by the terms and conditions herein.
I/we have read the above Patient Consent for Treatment, Services and Payment, have had the opportunity to ask questions for clarification and understand the same and certify that no guarantee or assurance has been made as to the results that may be obtained as related to such treatment and services.

I understand McLeod Health, which includes MPA, has an electronic health information exchange which will be used to send my health information to myself or to my physicians.

_____	_____	_____
Patient or (Authorized Representative)	Date	Witness

_____
Financially Responsible Party

_____	_____	_____
Patient's Name	Account Number	Treatment Date

Acknowledgement of the Notice of Privacy Practices

I/we hereby acknowledge that I/we have been offered a paper copy of the McLeod Health Notice of Privacy Practices, which sets forth the manner in which the protected health information of the patient named below may be used or disclosed by MPA and/or McLeod Health and outlines applicable rights with respect to such information. I/we also acknowledge that I/we have been allowed to ask questions as related to the Notice of Privacy Practices. If I/we am not the patient, I/we represent that I/we am authorized by law to act for and on the patient's behalf as indicated below.

_____	_____
Signature of Patient or Authorized Representative	Date

MCLEOD PHYSICIAN ASSOCIATES

PATIENT ACKNOWLEDGEMENT OF ELECTRONIC MEDICAL RECORD USE, ACCESS, AND SHARING

McLeod Physician Associates ("MPA") is a network of physician providers and primary, surgical and specialty medical offices (the "MPA" Network") that utilize an electronic medical record system ("EMR") in order to document and review the health care services you receive through MPA and the MPA Network. It is very likely that additional providers will be joining the MPA Network in the future. As such, this Acknowledgement applies to the MPA providers who render care to you both now and in the future.

When you receive medical care through MPA or the MPA Network, all of the information about your treatment will be combined into one EMR that will be shared by your MPA Providers within the MPA Network. Use of the EMR allows your health care providers to coordinate your care, improve the exchange of important information about your treatment, and make clinical information available about the care that is provided to you. The clinical information that is shared may include items such as lab test results, operative reports, office visit notes, x-ray reports, hospital discharge summaries, and other clinical information relating to you and the care you receive. **This confidential information may also include some or all of the following: diagnostic or treatment information relating to mental health or psychiatric conditions; information relating to referrals for, or the diagnosis or treatment of, drug or alcohol abuse; genetic testing information or results; information relating to being a victim of, or counseling about, domestic abuse, neglect, or violence; and/or HIV/AIDS test results or treatment.**

The shared information will only be used for the provision of medical treatment to you, payment for that treatment, or certain limited health care operations uses, which are permitted under HIPAA-the federal Privacy Rule. Once your information is combined, it cannot be separated.

MPA and the MPA Network are committed to protecting and maintaining the confidentiality of your medical care and treatment and have policies and procedures in place to protect your health information. Access to your EMR is tracked and this access may be audited to assure that it is appropriate.

By signing below you are confirming your acknowledgement of the use of an EMR in order to access and share protected health information by MPA and the MPA Network and that you are in agreement with such sharing, exchange, and use of your protected health information in order to provide medical care and carry out services related to your treatment.

This Acknowledgement applies to health records that MPA already has about you as well as future care that is rendered to you.

I hereby acknowledge that I have been informed as to the use, access and sharing of my health records and medical information as described in this Patient Acknowledgement of Electronic Medical Record Use, Access, and Sharing.

_____ _____

Patient's (or Personal Representative's) Signature Date

_____ _____

Name of Personal Representative Relationship to Patient

CONSENT TO APPEAL INSURANCE DENIAL

In the event my insurance carrier denies a claim, I hereby give my consent for Pee Dee Surgical Group to appeal that denial in order to receive payment.

_____ _____

Patient's (Guarantor's) Signature Date

_____ _____

Patient's Name Witness