PALMETTO CARDIOLOGY ASSOCIATES

Patient Registration Form

Patient's Name (Last, First, MI): _____

Patient's Home Phone Number: _____ Alternate Phone Number (☐ cell or ☐ work): _____

E-Mail Address: _____

Address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Sex: M F Social Security Number: _____

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed

Patient's Employer: _____

Employment Status: [ ] Full time [ ] Part time [ ] Unemployed
[ ] Retired [] Student [ ] Other: _____

Emergency Contact: _____ Relationship to Patient: _____

Address: _____ Phone number: _____

INSURANCE INFORMATION

Primary Insurance: _____

Patient is Subscriber/Policy Holder: Y N

Secondary Insurance: _____

Patient is Subscriber/Policy Holder: Y N

INSURED INFORMATION (IF OTHER THAN PATIENT) - We will request to scan your ID and insurance card

Subscriber/ Policy Holder: _____ Relationship to Patient: _____

Address: _____

Social Security Number: _____

Date of Birth: _____

His or Her Employer: _____ Work Phone Number: _____

RELEASE OF INFORMATION

I hereby give permission to the person(s) listed below to receive information about the care of the above-named patient.

Name(s): _____ Relationship to Patient: _____

Palmetto Cardiology Associates reserves the right to charge a fee for any scheduled visits that are:

1. 1.Cancelled with less than 24 hours' notice
2. Are missed without calling to cancel (no show)

Cancellation Fee schedule: New Patient $50.00; Established Patient: $35.00, Echocardiography Testing, $75.00, Nuclear Testing $160.00

Patient / Parent or Guardian Signature: _____ Date: _____

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HEALTH HISTORY

Personal Information Date: _____

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

Occupation _____ Marital Status: _____ Name of Partner/Spouse: _____

Race: [ ] Asian [ ] Black or African American [ ] Native American [ ] White / Caucasian

[ ] Other: _____

Ethnicity: Do you identify with an Ethnic origin? If yes, please note: _____

Names/Specialties/Locations of Other Physicians Caring for You, including previous primary care doctor:

_____

_____

_____

Medical Information

Please list any **MEDICATIONS** you are currently taking, prescribed or over the counter (use the back of the page if needed and indicate so):

Medication	Dosage	Route	Frequency

Any **Allergies** to Medication or Food (list reactions): _____

Are you allergic to any of the following? _____X-ray or Contrast Dye _____Iodine

_____Shellfish/Seafood/ Shrimp _____Local Anesthetics

Preferred **Pharmacy**: _____

Date of Last Complete Physical Exam: _____ Date of Last Blood Work: _____

Date of Last Colonoscopy: _____ Date of Last Tetanus Shot: _____

PALMETTO CARDIOLOGY ASSOCIATES

If **YOU** have had any of the following, please place a check or an" X" next to what applies.

—	Angina/ Chest Pain	—	Heart Attack	—	Gallbladder Problems
—	Asthma/ Emphysema	—	Heart Failure	—	Leg Pain While Walking
—	Anxiety / Panic Attacks	—	Heart Murmur	—	Thyroid Problems
—	Aneurysm	—	Hepatitis	—	Rheumatic Fever
—	Anemia	—	High Blood Pressure	—	Leg / Ankle Swelling
—	Blood Clots	—	High Cholesterol	—	Weight Gain
—	Bleeding Problems	—	Heart Catheterization	—	Liver Disease
—	Bleeding Ulcers	—	Heart Surgery	—	Neurological Disease
—	Childhood Heart Ailment	—	Hiatal Hernia	—	Respiratory Disease
—	Cancer	—	Kidney Stones	—	Stomach / Colon Disease
—	Coughing Spells	—	Kidney Failure	—	Watchman
—	Coronary Artery Disease	—	Mitral Valve Clip or repair	—	Heart Disease
—	Coronary Angioplasty or	—	TAVR	—	Sudden Death
—	Stent	—	Pacemaker		
—	Type 1 or 2 Diabetes	—	Stroke		
—	Difficulty Urinating	—	Infective Endocarditis		
—	Fainting / Dizzy Spells	—	Shortness of Breath		
—	HIV Positive	—	Pneumonia		
—	Heart Monitor	—	Sarcoidosis		
—	Covid-19	—	Varicose Veins		
		—	Weight Loss		
		—	Echocardiogram		
		—	Palpitations (heart racing)		
		—	Valvular Heart Disease		

Do you have **Family History** of **Heart Disease**, **Sudden Death**, **High Blood Pressure**, **Diabetes,** or **Aortic Aneurysm,** please circle any that may apply?

Please list any **SURGERIES** you have had or planning to have include the month/year:

_____

Social Information

Tobacco Use: Do you smoke? _____ If so, how many cigarettes/cigars per day: _____ No. of years smoking: _____ Do you chew tobacco? _____ Have you thought about quitting? _____ Have you quit before? ____ Do you use smokeless devices? _____ Do you Vape? _____

Alcohol Use: Do you drink alcohol? ____

Drug Use: Any history of illegal drug use? _____ If so, what type/s? _____ When? _____

Would you accept a Blood Transfusion if needed? _____Yes _____No

Have you had the **Covid Vaccine**? _____if so, give the date of last shot_____

Do you have a living will? ____If yes, please provide us a copy. If no, would you like information? ___

PALMETTO CARDIOLOGY ASSOCIATES

Authorization for Claims Payment and Reviews

1. **Assignment and Coordination of Insurance Benefits** - I agree to provide information regarding all group hospitalization, health maintenance organization, Workers' Compensation, automobile, and other health care benefits ("Insurance Plan(s)") to which I may be entitled. I hereby assign payment(s), if any, from my Insurance Plan(s) to Palmetto Cardiology Associates (or its affiliate) and each of the independent contractor physicians and/or professional corporations for services rendered to me. The direct payment hereby assigned and authorized includes any Insurance Plan(s) benefits to which I am otherwise entitled, including any major medical benefits otherwise payable to me under the terms of my policy, but is not to exceed the balance due to PCA (or its affiliate), the independent contractor physicians and/or professional corporations for services rendered to me during the applicable periods of medical care.

2. **Unauthorized, Non-Covered, or Out of Plan Services** - I understand if my Insurance Plan(s) does not consider this admission or any service rendered during this admission a covered service or has not authorized this service, they will not pay for this admission, or the service rendered during this admission or outpatient visit. I agree to be fully responsible for payment to PCA for this admission or any service if determined by my Insurance Plan(s) to be a non -covered service. I also understand and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay a larger co-payment, co-insurance, or other charge in the event my Insurance Plan(s) does not reimburse these services provided to me, I acknowledge I will be responsible for any remaining balance.

3. **For Medicare Recipients Only** - I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to the Hospital and/or independent contractors for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for the related services. In the case of Medicare Part B benefits, I request payment either to myself or to the party who accepts assignment.

4. **Residents, Interns or Medical Students-** I understand residents, interns, medical students, and other health care professional students may participate, under the supervision of an attending physician or other health care professional, in my care as part of the Palmetto Cardiology Associates education programs.

By signing below, I certify I have read and understand the foregoing, have had the opportunity to ask questions and have them answered and accept the above conditions and terms and I agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductibles, co-payments, and non-covered. I also agree in the event my account must be placed with an attorney or collection agency to obtain payment, I will pay the reasonable attorneys' fees and other collection costs incurred by Palmetto Cardiology Associates. *I understand and agree this document will remain in effect for all future outpatient or physician office visits to any Palmetto Cardiology Associates facility, unless specifically rescinded in writing by me.*

Patient Signature: _____ Date: _____

Relationship to Patient: _____

PALMETTO CARDIOLOGY ASSOCIATES

I certify that I have been made aware of Palmetto Cardiology Associates, P.A. **Notice of Privacy Practices** and that I have a right to receive a copy upon request. This Notice describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of Palmetto Cardiology Associates health care operations. The Notice also describes my rights and Palmetto Cardiology Associates duties with respect to my protected health information. I understand that copies of the **Notice of Privacy Practices** are available in the registration areas of each facility and on Palmetto Cardiology Associates web site at www.palmettocardiology.com. I may request that a copy be mailed to me by calling **803-252-6644.**

Palmetto Cardiology Associates reserves the right to change the privacy practices that are described in the **Notice of Privacy Practices**. I may obtain a revised **Notice of Privacy Practices** by calling the above number and requesting a revised copy be mailed to me, by asking for one at the time of my next appointment, or by accessing Palmetto Cardiology Associates web site listed above to view the most current version.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

NAME OF PATIENT OR PERSONAL REPRESENTATIVE

DATE

DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY

PATIENT IDENTIFICATION

Palmetto Cardiology Associates, P.A.

ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

CAT #84498 / R032103
PKGS OF 100

MR 32-06