



**Patient Information**

Last Name: \_\_\_\_\_  Mr.  Mrs.  Miss  Other: \_\_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_  
First Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_ - \_\_\_ - \_\_\_\_\_  
Middle Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Home Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_  
May we leave a message about appointments or normal test results on the phone numbers you provided? Yes \_\_\_\_\_ No \_\_\_\_\_  
Would you like to receive appointment reminders via text message? Yes \_\_\_ No \_\_\_ (If yes, please provide cell phone number above.)  
Marital Status:  Married  Single  Separated  Divorced  Widowed  Partner  Unknown  
Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Other: \_\_\_\_\_  
Primary Language:  English  Spanish  French  Other: \_\_\_\_\_  
Race:  Caucasian  African American  Asian  Other: \_\_\_\_\_  
Student Status:  Not a Student  Full  Part  
Employment Status:  Full  Part  N/A Employer: \_\_\_\_\_  
Pharmacy name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_  
Emergency Contact: Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_  
Alternate Contact: If you want this Practice to contact you at an alternate address or telephone number, please complete:  
Alt. Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_  
Referred by: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

**Guarantor/Financially Responsible Person (if different from patient)**

Last Name: \_\_\_\_\_  Mr.  Mrs.  Miss  Other: \_\_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_  
First Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_ - \_\_\_ - \_\_\_\_\_  
Middle: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_  
Guarantor/Financially Responsible Person's Email Address: \_\_\_\_\_

**Primary Insurance**

**Secondary Insurance**

Insurance Company: \_\_\_\_\_  
Policyholder Name: \_\_\_\_\_  
Member or Policyholder ID#: \_\_\_\_\_  
Policyholder Date of Birth: \_\_\_\_\_  
Insurance Co. Phone #: \_\_\_\_\_  
Group#: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_

Insurance Company: \_\_\_\_\_  
Policyholder Name: \_\_\_\_\_  
Member or Policyholder ID#: \_\_\_\_\_  
Policyholder Date of Birth: \_\_\_\_\_  
Insurance Co. Phone #: \_\_\_\_\_  
Group#: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_

## Consent for Treatment, Authorization, Assignment of Benefits, and Referral Release

**CONSENT FOR TREATMENT:** I consent and authorize a Roper St. Francis Physician Partners (“RSFPP”) physician or designated qualified assistant to provide me medical treatment and to use and release my protected health information for treatment, payment, and healthcare operations as allowed by HIPAA and as described in the RSFH Notice of Privacy Practices, a copy of which has been made available to me.

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:** I understand that my medical information, including complete medical records, test results, and billing information, may be released to my insurance company and to other medical professionals and/or medical care institutions for treatment and payment purposes.

**ASSIGNMENT OF INSURANCE BENEFITS:** I hereby assign all my rights and allow payment to be made directly to RSFPP for all medical or surgical benefits otherwise payable to me under terms of my insurance.

**PAYMENT GUARANTEE:** I understand and agree that I am responsible for paying all co-payments, co-insurance, deductibles, and non-covered services rendered by RSFPP, including charges for services not covered by my insurance. I consent and authorize RSFPP and third party agents of RSFPP to contact me by telephone at any number associated with me, including a wireless number, and to use a pre-recorded and/or an automatic dialing service in connection with any communication made to me or related to my account.

A photocopy of this form shall be considered as effective and as valid as the original.

To the best of my knowledge the information I have given on this form is accurate and true. I know it is my or my legal guardian’s responsibility to keep RSFPP informed of changes to my contact information; a failure to do so may interfere with the ability to contact me concerning my healthcare.

Print Patient’s Name: \_\_\_\_\_

Patient’s Signature: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Print Legal Guardian’s Name: \_\_\_\_\_

Legal Guardian’s Signature: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Consent is valid for one year from date signed.**

## Ongoing Communication Regarding Your Healthcare

**DO YOU WISH TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM RSFPP MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? (Please provide the information below.)**

For **ongoing communication** regarding your healthcare and for your privacy, you must complete this section to authorize RSFPP to release and/or discuss your health information with the following people or entity(s) for the specific dates of service or event(s).

\*Any revocation or modification to your authorization with regard to an individual or organization must be submitted in writing.

**PLEASE NOTE:** By listing an individual(s) and/or entity(s) below, you authorize ALL RSFPP physician offices to release and/or discuss your health information with the individual(s) and/or entity(s).

From date of service/event(s): \_\_\_\_\_ To date of service/event(s): \_\_\_\_\_

Name of Individual/Entity	Phone Number	Relationship	Address
<i>Example: John Doe</i>	<i>843-555-1212</i>	<i>Husband</i>	<i>123 Main Street, Charleston, SC 29403</i>
_____	_____	_____	_____
_____	_____	_____	_____

A separate **Authorization to Release Information Form** must be completed to release and/or discuss your health information with any individual(s) and/or entity(s) not listed in the section above.

To request restrictions of the use of your information, you must complete a separate **Request to Restrictions Form**.

For your convenience, please list below the individual(s) that you authorize to receive prescriptions from your RSFPP provider(s).

Name of Individual	Phone Number	Relationship	Address
_____	_____	_____	_____
_____	_____	_____	_____