Trinity Family Practice Anderson

Christine Lawrence, MD

PATIENT INFORMATION

Social Security #:		Date of Birth:					
Full Name:			Name you wish to be called:				
Mailing Address:	Street Address		City and State		Zip Code		
Home Phone #:		Cell Phone #:					
Email Address:		I prefer to be notified by: (Circle One)	Mail Phone Email				
Age:	**Gender:**	**Race:**	**Language Preference:**	English Spanish Other (Please Specify)			
Ethnicity: (circle one)	Hispanic/Latino Not Hispanic/Latino	Marital Status:	S M W D SEP				
Employment Status:	Full Time Part Time Self Retired None	Student Status:	Full Time Part Time None				
Employer/School Name:		Work Phone #:					
Employer Address:							
Previous Provider's Name:		Previous Provider's Phone Number and Address:					
Emergency Contact Name & Phone #:							
Do you have Advanced Directives? YES NO If yes, circle type Health Care Power of Attorney/Living Will ___ DNR___							
Social Security #: _____ Date of Birth: _____ If patient is a MINOR list parent/guardian name and phone #: _____							

INSURANCE INFORMATION

	Primary	Secondary	Tertiary
Subscriber (Legal Name):			
Telephone:			
Relation to patient:			
Date of Birth:			
Social Security #:			
Employer:			
Employer Address:			
City, State:			
Zip Code:			
Employer Phone:			
Insurance Company:			
Subscriber ID #:			
Group #:			
Patient ID (if different):			
Insurance Phone #:			

BENEFIT ASSIGNMENT AND RELEASE OF INFORMATION

I, the undersigned, for myself or a minor child or another person for whom I have authority to sign, hereby consent to medical care and treatment as ordered by a physician and certify that the insurance information listed above is correct and that all insurance benefits for services rendered are directly assigned to Trinity Family Practice Anderson, LLC and/or Trinity Family Practice, LLC. I understand that I am financially responsible for all charges regardless of benefits. I hereby authorize the release of all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance claim submissions. Should this account be turned over to a collection agency for collection, I understand and agree that I will be obligated to pay all collection costs, including, but not limited to, reasonable attorney's fees.

Signature:_____ **Date:** _____

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Welcome to Trinity Family Practice Anderson. Thank you for your interest in becoming a patient in our office. Please read the following instructions and office guidelines.

Instructions for completing new patient packet:

- Please fill out paperwork completely and return the completed packet to the office before your scheduled appointment. All questions must be addressed.
- You may use "n/a" or none if applicable
- Use blue or black ink only
- Please list **all** medications, ***including over the counter medications*** that you take on a daily basis or as needed.

Office Guidelines:

- Bring your insurance card to every appointment.
- Bring **all** medications in the original bottles to every appointment.
- Copays are expected at the time of service.
- Our providers DO NOT routinely prescribe anxiety or pain medications for long term use and reserve the right to not prescribe them at all.
- New patient appointments require more time to be reserved on our schedules. If you are unable to keep your appointment, please call to cancel or reschedule your appointment so we can utilize the slot for another patient.
- Please call 24 hours prior to your appointment time to cancel or reschedule any appointment you will not be able to attend. Otherwise, you will be charged a $50 no-show fee.
- Should you "no-show" 2 appointments, you will be at risk for being discharged from the practice.

Your signature acknowledges that you have been informed of our office guidelines.

_____ _____ _____

Patient/Guardian Signature **Date** **Time**

_____

Patient/Guardian Name Printed **Relationship**

4144 Clemson Boulevard, Anderson, SC 29621
Phone: 864-224-9598, Fax: 864-226-2462
TrinityFamilyPracticeAnderson.com

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PATIENT FINANCIAL AGREEMENT

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. We ask all patients to review and sign this policy. A copy will be provided upon request.

1. Insurance. We participate in most insurance plans, including Medicare. **If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage.** Please contact your insurance company with any questions you may have regarding your coverage.

2. Copayments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your copayment at each visit.

3. Non-covered services. Please be aware that some of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Forms: There is a $50 fee for completing FMLA, sick leave, AFLAC, and disability insurance forms. This fee must be paid before the forms are completed.

5. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

6. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their requests. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

7. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

8. Uninsured patients: We offer a 30-percent discount to our patients who do not have insurance. Be advised that the discount is only good when the charges are paid ***at the time of service***. If a balance remains, you will receive a monthly statement that is due upon receipt. Account balances over 90 days will be subject to review for collection action.

9. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

10. Missed appointments. Our policy is to charge $50 for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointments or providing at least 24 hours notice of cancellation.

We are committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of patient or responsible party **Date**

Name Printed:_____

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Trinity Family Practice Anderson (TFPA) may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to TFPA's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. TFPA reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: Trinity Family Practice Anderson Privacy Officer, 4144 Clemson Boulevard, Anderson, SC 29621.

With my consent, TFPA may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others.

With my consent, TFPA may mail to my home/other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, TFPA may email to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. I have the right to request that TFPA restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to TFPA's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, TFPA may decline to provide treatment to me.

I understand that my medical records may be transmitted electronically by fax and may be received in error by a third party. In the event that this should occur I absolve this practice of all liability.

I give my consent to fax my records for the purposes of treatment, payment or healthcare operations and understand that I may withdraw this consent at any time in writing.

If I choose to email my healthcare provider(s), I understand that email is considered a convenience and is not appropriate for emergencies or time-sensitive issues. I also understand that highly sensitive or personal information should not be communicated via email.

I understand that although safeguards will be made to protect the confidentiality of any information contained within email, no one can guarantee the absolute privacy of email messages and that depending on their job function, staff may have the right to access any email sent or received by my healthcare provider(s).

I give my consent to include any emails pertinent to the treatment, payment or healthcare operations in my medical record. Finally, I understand that I may withdraw this consent at any time in writing.

Patient/Guardian Signature **Date**

Patient/Guardian Name Printed **Relationship to Patient**

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PATIENT NAME: _____ DOB:_____

To maintain the HIPAA Privacy Practices, Trinity Family Practice Anderson must have your permission for any contact that may be necessary.

The email address you provide us may be used to notify you of scheduled appointments. Please use an email address that you are comfortable receiving confidential personal health information.

Please answer the questions below, so we may ensure that we do not breach your confidentiality in any way. We at Trinity Family Practice Anderson strive to provide the best quality of care in a competent and compassionate manner and appreciate your cooperation in this process.

1. How do you prefer to be contacted? ☐ Phone ☐ Mail ☐ Email _____
Email Address

2. If by phone, may we leave information on your voice mail or answering machine at the number you provide at registration, concerning your health? ☐ Yes ☐ No

3. Please list below names of people to whom we may talk or release records on your behalf regarding your protected health information.

FULL NAME	RELATIONSHIP	CONTACT INFO

OR

☐ I do not wish for my protected health information to be given to anyone except other healthcare providers for continuity of care (ex. physician to whom I am referred, EMS for transfer, or other hospitals in an emergency situation).

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent in writing except where we have already made disclosures in reliance on your prior consent. Otherwise this consent will expire one (1) year after the date you signed.

Patient Signature_____ Date/Time _____

OR Personal Representative/Guardian (relationship to patient) _____

Name Printed_____

Witness_____ Date/Time_____

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AUTHORIZATION OF RELEASE OF PROTECTED HEALTH INFORMATION

Full Name _____ Date of Birth _____

Social Security Number _____

Current Address: _____

_____

By signature below, I authorize:

Previous Provider Name _____

Address _____

_____

Phone # _____

To disclose to: Trinity Family Practice Anderson
4144 Clemson Blvd
Anderson, SC 29621

My protected health information as described below for the following purpose:

_____ Last 3 clinical notes, lab results, radiology reports, vaccine records
_____ Other :_____

This authorization for release/disclosure of protected health information is effective for one year from the date signed below. This informed consent is subject to revocation at any time by written notification only.

Patient signature _____ Date _____

Signature of legal representative _____

Date _____ Relationship _____

Witness _____ Date _____

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Informed Consent for Telehealth Visits

What is telehealth?

- Telehealth is a way to visit with healthcare providers without having to visit their office. You can talk to your provider from any place, including your home.

How do I use telehealth?

- You will simply follow the instructions given to you by a staff member on your phone, tablet, or computer.

How does telehealth help me?

- You don't have to go to a clinic or hospital to see your provider.
- You won't risk getting sick from other people or getting other people sick.
- Providers may be able to fulfill some requirements for refilling certain medications.

Can telehealth be bad for me?

- You and your provider won't be in the same room, so it may feel different than an office visit.
- Your provider will not be able to perform certain portions of your exam such as vital signs.
- Your provider may decide you still need an office visit.
- Technical problems may interrupt or stop your visit before you are done.

Will my telehealth visit be private?

- We will not record visits with your provider. We use telehealth technology designed to protect your privacy.
- You should be in a private place, so other people cannot hear you.
- There is a very small chance that someone could use technology to hear or see your telehealth visit, however, using a secure internet connection will mitigate that risk.

What if I want an office visit, not a telehealth visit?

- You may decline a telehealth visit and request an in-office visit at any time based on availability

How much does a telehealth visit cost?

- What you pay depends on your insurance company.
- If your provider decides you need an office visit following your telehealth visit, you may have to pay for both visits.

What does it mean if I sign this document?

If you sign this document, you agree to the following:

- You have read and understand the information provided above regarding telehealth.
- You hereby give your informed consent for the use of telehealth in your medical care for diagnosis and treatment.
- You hereby authorize Trinity Family Practice Anderson to bill your insurance for telehealth services provided.
- You understand that you are responsible for any bills the same way you would be for an in-office visit.

How will my care be affected if I sign this document?

- This document simply allows us to use telehealth during your treatment. At any time, you may request or decline a telehealth visit.
  - If you are requesting one, your provider may determine that you cannot be adequately cared for using telehealth.
  - If you are declining one, you may have to wait for an in-office appointment if one is not available.

Your name (please print) Date

Your signature Date

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_____
TODAY'S DATE

_____
PATIENT'S NAME

_____ _____
DATE OF BIRTH AGE

PLEASE ANSWER EACH QUESTION CAREFULLY

ARE YOU? (circle one): MARRIED SINGLE DIVORCED WIDOW(ER)

SPOUSE'S NAME: _____ # CHILDREN: _____

OCCUPATION (PRIOR IF RETIRED)_____

REASON FOR THIS OFFICE VISIT / HEALTH CONCERNS: _____
_____

EDUCATION: _____

YOUR MEDICAL HISTORY (circle and give dates if yes)

BLOOD TRANSFUSIONS
HEART DISEASE / MURMUR / HIGH BLOOD PRESSURE / STROKE / AFIB
EPILEPSY / SEIZURES / MIGRAINE HEADACHES
ANXIETY / DEPRESSION / EMOTIONAL ILLNESS / BIPOLAR DISORDER
LUNG DISEASE (TB / ASTHMA / COPD / INTERSTITIAL LUNG DISEASE)
PHLEBITIS / BLOOD CLOTS / PULMONARY EMBOLISM / DVT
KIDNEY DISEASE / THYROID DISEASE / DIABETES
HEPATITIS / LIVER DISEASE / GALLBLADDER DISEASE
ALCOHOL OR DRUG ABUSE / EATING DISORDER (ANOREXIA OR BULIMIA)
RAPID WEIGHT CHANGES UP OR DOWN
ANEMIA / BLOOD DISORDER
CANCER (Type/Year)_____
COLLAGEN VASCULAR DISEASE (SUCH AS LUPUS)
ARTHRITIS / BACK PROBLEMS / BONE FRACTURES
URINARY OR KIDNEY PROBLEMS / BOWEL PROBLEMS / COLITIS
SEXUAL PROBLEMS
EVER TAKEN: HEPARIN / STEROIDS / THYROID MEDICATION
EVER HAD CHOLESTEROL (LIPID) TEST
EVER HAD A COLONOSCOPY (SCOPE IN RECTUM)
IMMUNIZATIONS: COVID, PNEUMONIA, SHINGLES, TDAP, RSV

LIST SURGERIES OR HOSPITALIZATIONS FOR ILLNESS:

_____
_____
_____
_____

LIST OTHER PROVIDERS (AND SPECIALTY) INVOLVED IN YOUR CARE:

_____
_____
_____
_____
_____

GYNECOLOGICAL HISTORY (FEMALES ONLY)

AGE WHEN PERIODS BEGAN: _____
CURRENT BIRTH CONTROL METHOD: _____
EVER USED: IUD OR BIRTH CONTROL PILLS (circle if yes)
DATE (YEAR) OF LAST PAP SMEAR: _____
DATE (YEAR) OF LAST MAMMOGRAM: _____
DATE (YEAR) OF LAST BONE DENSITY_____
DATE OF LAST MENSTRUAL PERIOD: _____ / _____ / _____

YOUR PERSONAL HISTORY

ALLERGIES / REACTION TO MEDICATIONS: _____
_____
_____

OTHER ALLERGIES: _____

CURRENT MEDICATIONS

Medication	Dose	Times Per Day

SMOKER (FORMER OR CURRENT) NUMBER OF CIGS PER DAY? _____
ALCOHOL USE (HOW MUCH, HOW OFTEN) _____
EXERCISE TYPE: _____ HOW OFTEN? _____

FAMILY HISTORY: DISEASE IN PARENTS, GRANDPARENTS, SIBLINGS, CHILDREN, AUNTS, UNCLES AND COUSINS (circle if yes and write down which family member)

CANCER: COLON/ BREAST/ OVARIAN/ UTERINE/ PROSTATE /LUNG / OTHER
DIABETES / HIGH BLOOD PRESSURE
HEART DISEASE / HEART ATTACK / HIGH CHOLESTEROL / STROKE
KIDNEY DISEASE
OSTEOPOROSIS (THIN BONES), HIP FRACTURE
PREMATURE MENOPAUSE
ALZHEIMER'S DISEASE
BLEEDING OR BLOOD CLOTTING PROBLEMS
OTHER: _____
_____
_____

PATIENT'S SIGNATURE

PATIENT'S NAME PRINTED

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