

South Carolina Psychiatric Group – New Patient Registration Form

68 Parkway Commons Way, Greer, SC 29650 - Phone: 864-877-5688 - Fax: 864-877-5684

Patient Information

Today's Date _____ / _____ / _____ SS# _____ - _____ - _____

Patient's name _____
FIRST MIDDLE LAST

Birth date _____ Age _____ Sex: F M Former name _____

Address _____ **City** _____ **State** _____ **Zip** _____

Primary # _____ **Secondary #** _____ **Other #** _____

Email _____ May we leave a message: Y N

Occupation _____ Employer _____ Work # _____

Primary Pharmacy Information

Pharmacy Name _____ Pharmacy Number _____

Pharmacy Address _____

Physician/Emergency Contact

Emergency Contact _____ Relationship to patient _____ Phone _____

Primary Care Physician _____ Phone _____

Referring physician's name _____ or referred by _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize South Carolina Psychiatric Group or insurance company to release any information required to process my claims. I understand that payment in full is due at each office visit.

By signing below, I am consenting to treatment.

Patient/Guardian signature _____

Date _____

Today's date _____ Date of birth _____ Age _____

Name _____

Please list current medications you are taking:

Medication Name	Dosage	Last Used

*Do you need to list more medications? No Yes (Please use the back of this paper to continue)

Psychiatric medications taken in the past _____

Drug Allergies: No Yes _____

Do you smoke? No Yes

List any ongoing medical conditions and surgeries you have undergone:

List any psychiatric conditions that you have been diagnosed with: _____

List previous healthcare providers (mental and medical): _____

Who lives in your household? (ei: son, spouse, mother-in-law, etc.): _____

Please Circle: Married Single Separated Widowed Other _____

Number, age and gender of children _____

Is your mother alive? Yes No Uncertain Is your father alive? Yes No Uncertain

List any family history of substance abuse or mental illness: Children _____

Parents _____ Grandparents _____

Siblings _____ Other _____

Demographics:

American Indian or Alaska Native Asian Black or African American Hispanic White

Native Hawaiian or Other Pacific Islander Other Race Other Pacific Islander Unreported/Refused

Ethnicity: Are you Hispanic or Latino? Yes No Language: English Spanish Other _____

**South Carolina Psychiatric Group
HIPAA CONSENT FORM**

The HIPAA Privacy Rule provides federal protection for individual’s health information held by covered entities and their business associates and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of health information needed for patient care and other important purposes to those that the patient approves.

You may discuss my medical information with the following persons:

Name and Relationship _____

Name and Relationship _____

Please do not discuss my medical care with the following persons:

Name and Relationship _____

Name and Relationship _____

Please do not discuss my medical care with anyone.

Patient Initials _____

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Exchange of Information with other Healthcare Providers

I Authorize, South Carolina Psychiatric Group, to obtain and/or freely exchange medical records (Physician’s Notes, Therapy Notes, Medication List, etc.) with:

Name of doctor or therapist _____

Fax Number _____ Phone number _____

Patient Initials _____

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Acknowledgement of Receipt of Notices of Privacy Practices

We are required to provide you with a copy of our notice of privacy practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office’s notice of privacy practices.

Print Patient’s Name _____

Signature _____ **Date** _____

South Carolina Psychiatric Group
OFFICE POLICIES

KEEPING YOUR APPOINTMENTS

Please call 24 hours in advance to change or cancel your appointment. We do not reschedule initial evaluation appointments that are not cancelled 24 hours in advanced or missed (no-show) unless a \$185 fee is paid prior to rescheduling. For established patients, a \$40 fee for the first missed appointment or last-minute cancellation and \$70 for second. You will be financially responsible for this fee as insurance plans do not cover these charges. We must have your correct phone number for us to give you a reminder courtesy call.

Please note: Repeated missed appointments and last-minute cancellations can result in discharge from this practice.

PAYMENTS/BILLING

ALL FEES, BALANCES, CO-PAYMENTS AND DEDUCTABLE AMOUNTS ARE DUE ON THE DAY OF YOUR VISIT. We accept payment through debit cards, credit cards or cash. We do NOT accept checks. We will file covered charges to your primary insurance only. We do not file secondary insurance. Please note: We do not file MEDICARE.

DELINQUENT ACCOUNTS

If you have a past balance you may be denied a future appointment until balance is paid off. Fees not covered by insurance are your responsibility.

MEDICATION REFILLS AND PRE-AUTHORISATION

Medication refills will be evaluated on a case by case basis and may be subject to a \$25 fee. These will not be called in on days the office is closed, holidays or weekends. It is your responsibility to make sure you do not run out of medications prior to your next appointment. We do not call in medications for missed or cancelled appointments. Prior authorization for medications may be subject to a \$25 fee.

COPY OF RECORDS

Patients are directly responsible for payment for copy of records. The initial fee is \$10 and may increase if chart is archived (over 1 year in storage) or more than 15 pages.

LETTERS AND DISABILITY PAPERWORK

This office does not fill out Permanent Disability Forms. Short Term Disability Forms can be completed only if Dr. Sanchez or Dr. Jacobs takes you out of work. The fee is \$25.00 for completing these forms. Additional requests for information or more complex requests are subject to additional charges. Letters are also subject to a charge of \$15.

TESTIMONIES OR OTHER LEGAL EVENTS

Unless otherwise specified, expert witness or testimony in a court of law or conversation with attorneys, their staff or any other legally related individual, in person, by phone or by any other means, is subject to an initial fee of \$400 per hour charge. Time will be prorated by the minute. You are directly responsible for payment to this office. Time billed includes set up, travel time, waiting and any other activities which are directly involved with this event.

I have read all of the above and agree on all:

Signature

Printed Name

Date

Guarantor signature and name. Print relationship to patient.

PATIENT'S COPY - Please take this copy of our office policies that you signed.

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