Grande Dunes ObGyn & Facial Aesthetics

913 Medical Circle, Myrtle Beach, SC 29572
Tel 843.839.2229 Fax 843.839.2230

Patient Registration Form

Date:_____

First Name:_____ MI:_____ Last Name:_____

Date of Birth:_____ Age:_____ Race:_____ Social Security #:_____

Address:_____ Apt/Unit#:_____

City:_____ State:_____ Zip Code:_____

Primary Phone#:_____ Other Phone #:_____

Driver's License #:_____ Marital Status (circle): Single / Married / Divorced / Widow

Email:_____

Employment (circle): Full Time / Part Time / Student / None May we contact you at work? Yes / No

Employer/School name:_____ Employer Phone #:_____

Emergency Contact:_____ Relationship to you:_____ Phone#:_____

Spouse Information or Responsible Party (if Minor)

First Name:_____ MI:_____ Last Name:_____

Date of Birth:_____ Age:_____ Race:_____ Social Security #:_____

Address:_____ Apt/Unit#:_____

City:_____ State:_____ Zip Code:_____

Primary Phone#:_____ Other Phone #:_____

Email:_____ Relationship to Patient:_____

Employer:_____ Employer Phone #:_____

May we contact them at work? Yes / No

Primary Insurance Information

Name of Policy Holder:_____ Date of Birth:_____

Policy Holder's Relationship to Patient (circle): Self / Spouse / Parent

Name of Insurance Company:_____ Insurance Co. Phone#:_____

Policy Number:_____ Group Number:_____

Policy Holder's Employer:_____ Employer Phone #:_____

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices for the patient listed above.

_____ _____

Signature of Patient / Guardian Date

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COMPOUND AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:_____ **Date of Birth**:_____

Grande Dunes ObGyn & Facial Aesthetics is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Please CHECK entities / persons that YOU approve to receive information:

1.) **Can we leave information on your voicemail?** YES _____ NO _____

Telephone #:_____

If yes to the above, what information may we leave?

Lab Results ___ Pap Results ___ Imaging Results ___ Financial Info ___ Billing Info ___ Appts ___

Medical as follows: _____

2.) **Can we email information to you?** YES _____ NO _____

Email:_____

If yes to the above, what information may we leave?

Lab Results ___ Pap Results ___ Imaging Results ___ Financial Info ___ Billing Info ___ Appts ___

Medical as follows: _____

3.) **Please list anyone else you authorize us to leave information with:** (ie: **spouse / significant other / parent / etc)**

Name: _____ Telephone #: _____ Relationship to you:_____

Name: _____ Telephone #: _____ Relationship to you:_____

Name: _____ Telephone #: _____ Relationship to you:_____

What information may we leave?

Lab Results ___ Pap Results ___ Imaging Results ___ Financial Info ___ Billing Info ___ Appts ___

Medical as follows: _____

Rights of the Patient:

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending written notification to Grande Dunes ObGyn & Facial Aesthetics. I understand that a revocation is not effective in cases where information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ _____

Signature of Patient or Personal Representative Date

Description of Personal Representative (attach necessary documentation) _____

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Financial Policy

Patient Responsibility:

Patients are responsible for payment in full on their account regardless of insurance coverage. Patients are responsible for presenting current insurance information at the time of service, and for understanding the provisions and limitations of their insurance plan. The Doctor neither knows, nor can she adjust billing according to what is or not covered.

If Grand Dunes ObGyn & Facial Aesthetics is a participating provider with the patient's insurance, the patient will be responsible for payment of any deductible and co-payment at the time of service. Grand Dunes ObGyn & Facial Aesthetics will accept and bill the insurance company for the contracted fee. However, if the insurance company denies the charges or fails to pay any portion of the bill, the patient agrees to pay that portion immediately.

If Grand Dunes ObGyn & Facial Aesthetics is not a participating provider with the patient's insurance company, the patient will be responsible for payment in full of all charges at the time of service.

- Many insurance companies DO NOT cover preventative services (routine annual exams). Patients are responsible for payment of all non-covered services at the time of service.
- We are frequently asked to call in prescriptions. There is a $10.00 administrative fee for refills outside of an office visit. This charge is not covered by any insurance company and will be billed to the patient.
- There is a $40.00 fee for all forms that patients request our office to complete. This charge is not covered by any insurance company and will be billed to the patient.
- Medical appointments require at least 24-hour cancellation prior to appointment time otherwise will incur a $40.00 fee.
- Cosmetic appointments require at least 48-hour cancellation prior to appointment time otherwise will incur a $50.00 fee.
- Refunds for overpayment will be subject to a 3% service charge if original payment was made by credit card.

Medicaid:

We do not accept Medicaid when the patient has any other primary insurance coverage.

We DO NOT accept or file insurances (including Medicaid) retroactively from the date of services rendered.

Note: The waiver of deductibles and co-pays is unlawful and may be construed by the Federal Government as Insurance Fraud

YOU WILL BE RESPONSIBLE FOR ALL COLLECTION FEES.

I have read and agree with the above terms and conditions. I authorize the release of any medical information necessary to process insurance claims. I authorize payment of medical benefits directly to Grand Dunes ObGyn & Facial Aesthetics for services rendered.

_____ _____

Patient Signature Date