WELCOME TO TIDEWATER DOCTORS LLC!

We look forward to many years of medical service to you and your family. Our offices are conveniently located and open Monday thru Friday. If you have an emergency after hours or on the weekend, the answering service will contact the physician on your behalf.

PRESCRIPTIONS

Please allow 48 hours for prescription refills. If your prescription needs to be picked up at the office during operating hours be sure to provide identification to receive your prescription.

REFERRALS

On certain occasions, Tidewater Doctors LLC will refer a patient to a specialist or a medical facility for a procedure. Tidewater Doctors LLC will make every effort possible to obtain prior approval through your insurance company. It will be the patient's ultimate responsibility to make sure their insurance company has approved this visit or procedure, prior to the visit or procedure being performed.

PAYMENT OF SERVICES

Tidewater Doctors LLC accepts most major insurance companies. As a courtesy to our patients we will file with your insurance company. Please provide a valid insurance card and appropriate information so your claims may be files in a timely manner. Patients are responsible for copays and deductible at the time of service. We accept all major credit cards, personal checks, and cash. Payment is due at the time services are rendered.

Patient Registration Form

Date____________

Patient Name: (Parent/Guardian Information MUST be filled out BELOW if the patient is a minor)

First ________________________ M.I._____ Last____

Date of Birth: _____/______/______ SSN: ________________________ Sex: F M

Address: ________________________City: _____________ State: ______ Zip: _________________

Martial Status: Single Married Divorced Widowed Other Race: __________

Home# (______) _________________ Cell# _____________ Email Address:_____________________

Preferred Pharmacy: ____________________ *Local pharmacy. This will be used to electronically send prescriptions when possible

In order to have access to your Medication History, Tidewater Doctor needs your authorization. (PBM Consent)
Y N

Employer: ___________________________ Work Phone: (______) ________________________

Preferred Language: _____________________ Race _____________ Ethnicity: ________________

Responsible Party for Care & Payment Info (Mandatory for Minors & Patients with legal guardians)

Relationship to Patient____

First ________________________ M.I._____ Last ____

Date of Birth: _____/______/______ SSN: _______________________ Sex: F M

Address ____

Phones: Home (______) _________________ Cell ___________________ Work______________________

Insurance Information

Patient Name____

Primary Insurance Co. _________________________ Policy number: ______________________________

Policyholder Name: ______________________ Date of Birth: ____________SSN: _____/____/______

Secondary Insurance Co. _________________________ Policy number:____________________________

Policyholder Name: _______________________Date of Birth: _________ SSN: _______/_______/_______

Third Insurance Co. __________________________________ Policy number:_______________________

Policyholder Name: _____________________ Date of Birth: _________ SSN: _______/______/__________

Emergency Contact Name: _______________________________ Phone Number: _____________________

Patient/Legal Guardian Signature ___________________________ Date: ________________

Tidewater Doctors Employee Witness Signature _________________________________Date:____________

Designated Party Release

You may give Tidewater Doctors LLC written authorization to disclose your protected health information to anyone that you designate, such as a family member or personal representative. If you wish to authorize a person to receive your protected health information, please complete the form below. You may also use this form to give us consent to leave detailed information, such as results for labs, x-ray, prescription refills, and appointment reminders, on your home answering machine, voicemail at work, cell phone, email or with another party you designate.

Date:_______________________ Account/Chart#___________________________

Patient Name: ____

Date of Birth:__________________

I authorize **Tidewater Doctors LLC** to disclose my Protected Health Information (PHI) to the following individuals:

Name: _______________________________________ Phone:_____________________

- Can make medical decisions
- Power of Attorney
- Allow joining Telehealth

Name: _______________________________________ Phone:_____________________

- Can make medical decisions
- Power of Attorney
- Allow joining Telehealth

Name: _______________________________________ Phone:_____________________

- Can make medical decisions
- Power of Attorney
- Allow joining Telehealth

I authorize **Tidewater Doctors LLC** to communicate my Protected Health Information (PHI) to me via the following methods:

_____Detailed message on my home phone answering machine Phone:_______________

_____Detailed message on my voicemail at work Phone:_______________

_____Detailed message on my cell phone voicemail Phone:_______________

_____Email detailed Medical Information Email: _________________________________

Patient Signature:____________________________________Date:_____________

Tidewater Doctors LLC

Please fill out form completely. The following information will help us in providing you the best medical care and treatment possible. If you have questions, please ask the front desk clerk or the nurse. Thank you and we look forward to seeing you today!

Patient's Name:____ Today's Date:_______________
Date of Birth:___/___/____
Who is your Primary Care Doctor?____
Name Phone Number

Reason for your visit today: ____

List ALL medications you are currently taking (including over the counter and vitamins/supplements).

Medications MGS How Often

____
____
____
____
____
____

List any ALLERGIES

Medication Allergy Reaction

____
____
____

LATEX ALLERGY Y N ADHESIVE ALLERGY Y N

<u>Medical History of Patient</u>

Heart Disease	Y	N	Asthma	Y	N
High Blood Pressure	Y	N	Depression	Y	N
High Cholesterol	Y	N	Stroke	Y	N
Diabetes	Y	N	Hypothyroidism	Y	N
Seizure	Y	N	Cancer	Y	N
Mental	Y	N	Type of Cancer:____________________		

Other:_____________________________

<u>Social History</u>

Do you smoke?	Y	N	How many cigarettes per day?__________
Any other forms of tobacco?	Y	N	List:_______________________________
Do you drink alcohol?	Y	N	How often?_________________________
Do you use any illicit drugs?	Y	N	Marijuana ___ Cocaine___ Other___

Marital Status

Married   Single (never married)   Divorced   Separated   Widowed

What is your occupation?____

What is your highest level of educations?____

Family History

Does anyone in your family (living or deceased) have the following: (please check all that apply)

High Blood Pressure:	□Mother	□ Father	□ Sibling	□ Grandparents
High Cholesterol:	□Mother	□ Father	□ Sibling	□ Grandparents
Cancer:	□Mother	□ Father	□ Sibling	□ Grandparents
Stroke:	□Mother	□ Father	□ Sibling	□ Grandparents
Heart Disease:	□Mother	□ Father	□ Sibling	□ Grandparents
Diabetes:	□Mother	□ Father	□ Sibling	□ Grandparents
Depression:	□Mother	□ Father	□ Sibling	□ Grandparents
Mental (Specify)	□Mother	□ Father	□ Sibling	□ Grandparents
Hypothyroidism:	□Mother	□ Father	□ Sibling	□ Grandparents

Other:____

Surgical History

Please select /list all surgeries:			Surgery Dates:
Appendix	Y	N	________________
Tonsils/Adenoids	Y	N	________________
Hysterectomy	Y	N	________________
Gallbladder	Y	N	________________
C-Sections	Y	N	________________
Heart	Y	N	________________ (type of surgery)________________

Other:____

Vaccines

Tetanus Y N Date given__________   **Flu Shot** Y N Date given_________

Covid Vaccines/Boosters Y N Date given _________   **Shingles** Y N Date given _________

Pneumonia Y N Date given_________

Females Only

Are you pregnant? Y N   Last Menstrual Cycle:________________________

Last Pap Smear:________________   Abnormal Pap: Y N

How many times have you been pregnant?_________   How many live births:_______________________

Patient Consent/Financial Policy

Missed Appointments: A Missed Appointment fee may be charged if you do not show up for a scheduled appointment, or cancel with less than 24 hour notice. This fee must be paid before a new appointment is scheduled. You may be discharged from Tidewater Doctors LLC if you have more than 3 Missed Appointments.

Account Balances: Patient account balances are due within 30 days of the receipt of the billing statement. Balances must be paid prior to services being rendered. If you are unable to pay your balance in full, we will reschedule your appointment until payment arrangements have been established. If you have fail to make appropriate payment arrangements after 2 billing statements, your account may be turned over to an outside collection agency. If you have established a payment plan and fail to meet agreed upon terms, your account may be turned over to a collection agency. Accounts assigned to Collections may be charged a $50 fee. Accounts turned over to an outside collection agency may be discharged from this practice. If this is to occur, you will be notified by certified mail that you have 30 days to find alternative care. During that 30-day period, our physicians will only be able to treat you on an emergency basis.

Returned Checks: There is a $35.00 fee for returned checks. This fee plus your balance is due when you are notified of the returned check.

Insurance: TD participates with many, but not all, insurance plans. It is your responsibility to contact your insurance company to verify that we participate with your plan and the physician you will be seeing is in network with them. A **Valid Driver's License** and **Insurance Cards must be presented** at each visit. If you do not have your up to date insurance card, we will be happy to reschedule your appointment or classify your appointment as self-pay.

Self-Pay patients and patients who have not met their deductible are required to pay for services in full prior to leaving. It is your responsibility to inform us in a timely manner of any changes to your billing and insurance information. If an insurance company denies payment for incomplete or wrong information, it is your responsibility to make payment in full. Please be aware there is a time limit on how long we have to file insurance claims. If we miss the deadline because you did not provide us with the correct information, you will be responsible for payment in full. We request your assistance in following up with your insurance company to resolve any non-payment issues. It is your responsibility to pay the bill. Please be aware that some and perhaps all of the services you receive may be non-covered by Medicare or other Insurers. You are responsible for any and all portions of the bill not covered by your insurance plan. You must pay for these services in full at the time of visit. **Co-pays must be paid Prior to services being rendered.** Your Insurance Company may deny the claim if co-pays are not collected and you may be responsible for the entire charge. To prevent this, if you are unable to pay your co-pay, we will have to reschedule your appointment. **Deductibles and co-insurance fees must be paid at check-out**. Patients who are unable to pay for the services as required by their insurance will be required to speak with an account representative to set up a payment plan.

Patient Portal: A patient portal is a secure website that allows a patient to access their healthcare information using the internet.. Patient portals have many important features such as those that allow a patient to: Review notes from the provider and medication refill requests and many more functions. Please do not send the physician a message regarding scheduling an appt. The message to providers are to be **ONLY** medical questions or medication refills.

Consent for Treatment, Assignment of Benefits & Release of Information
Thank you for choosing Tidewater Doctors (TD) to meet your medical needs. We are dedicated to providing the best treatment available.
Carefully read, sign and date the bottom.

Patient Consent for Treatment
I voluntarily consent to any and all heath care treatment and diagnostic procedures provided by TD and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other healthcare professions is not an exact science and I further stat that I understand that no guarantee has been or can be made as to the results of treatments or examinations at TD.
Assignment of Benefits & Release of Information
I hereby authorize treatment of myself or the minor described above. I hereby authorize TD to release my medical information to facilitate payment and coordination of care for rendered services. I authorize payment from my insurance company be assigned to TD. I understand that I am ultimately responsible for the balance of my account.
I authorize the release of all medical information necessary for TD to meet State and Federal reporting requirements. If receiving medical services for employment, I authorize the release of the results of my exam to my employer.
I authorize TD to obtain and download all of my formulary, benefits, and ERX medication/prescription history when using an electronic system to prescribe medications. I acknowledge that I retain the right to review TD Notice of Privacy Practices in the office upon request.

Signature of Patient or Responsible Party: ___________________________ Date: ______________

Signature of TD Employee Witness: _____________________________________ Date: ______________

Tidewater Doctors LLC

Acknowledgement of Receipt of

Notice of Privacy Practices for

Tidewater Doctors

I , ________________________________ **Patient's Name / Personal Representative (as defined by HIPAA)**

hereby acknowledge that I have received the Notice of Privacy Practices for Tidewater Doctors LLC.

Signature**:** ____

Date: ____________________

Description of Personal Representation and please attach copy of documentation.

____

Documentation of "Good Faith" Attempt to get acknowledgement signature.

- ☐ Document presented to patient, but patient refused to sign acknowledgement.

- ☐ Patient presented with an emergency situation and there was no time to give the Notice or receive a signature. Attempt to get give the Notice, and get any acknowledgement will be handled as soon as possible.

- ☐ Documentation was presented to the patient but a communication failure prevented us from receiving the acknowledgement.

- ☐ The documentation was mailed to the patient but never returned to us.

- ☐ Other ____

Employee Preparing Document: ________________________________

Employee Signature ________________________________

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION

(please print)

Patient's Name: ________________________

Date of Birth: ___________________________

Phone Number: ___________________________

PLEASE RELEASE ALL MEDICAL RECORDS FOR TRANSFER OF PATIENT CARE

FROM: NAME OF PRACTICE: ____

PRACTICE FAX: ____

TO: Tidewater Doctors LLC

2270 Ashley Crossing Drive Ste 150

Charleston, SC 29414

PHONE NUMBER: 843-766-1936

FAX NUMBER: 843-766-1206

Please release a copy of all medical records, including but not limited to: vaccine records, progress notes, operative notes, laboratory / x-ray results, and diagnostic tests.

BY MY SIGNATURE I AUTHORIZE RELEASE OF ALL MEDICAL RECORDS

Patient Signature: __________________________________ Date ________________