HARBISON
MEDICAL ASSOCIATES
A Lexington Medical Center Physician Practice

Irmo Medical Park
7033 St. Andrews Road, Suite 205
Columbia, SC 29212
Ph: (803) 749-1155 • **FAX:** (803) 749-1786

Lexington Medical Center

Patient Information / Authorization Form

(Please print clearly)

Date: _____ **SS#:** _____

Patient Name: _____
(Last) (First) (MI)

Maiden/Other Name: _____
(Last) (First) (MI)

Address: _____

Apt./Lot: _____ **City:** _____

County: _____ **State:** _____ **Zip:** _____

Date of Birth: _____ **Age:** _____ **Martial Status:** ☐ S ☐ M ☐ D ☐ W **Sex:** ☐ F ☐ M

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Race: ☐ Decline to answer ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American
☐ Hispanic/Latino ☐ Native Hawaiian or other Pacific Island ☐ White ☐ More than one race

Ethnicity: ☐ Decline to Answer ☐ Hispanic or Latino ☐ Non Hispanic or Latino

Patient Speaks English: ☐ Yes ☐ No

Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Preferred Communication Method: ☐ U.S. Mail ☐ Home Phone ☐ Cell Phone ☐ Work Phone

EMERGENCY CONTACT

Last Name _____ First _____
Relationship _____ Home Phone _____
Work Phone _____ Cell Phone _____

NEXT OF KIN

Last Name _____ First _____ MI _____
Address _____
City _____ State _____ Zip _____
Relationship to Patient _____ Best Contact Number _____

Referred by: _____ **Primary Care Physician:** _____

Patient's Religion: _____ **Living Will:** ☐ Yes ☐ No

Power of Attorney: ☐ Yes ☐ No **Organ Donor:** ☐ Yes ☐ No **Do you have medical insurance?** ☐ Yes ☐ No

Patient Name: _____ DOB: _____

RESPONSIBLE PARTY INFORMATION

Responsible Party Name: _____
(Last) (First) (MI)

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ SS#: _____ Age: _____

Relationship to Patient: _____

PRIMARY INSURANCE TO FILE / SUBSCRIBER'S INFORMATION

Policy#: _____ Group#/Group Name: _____

Subscriber Date of Birth: _____ Subscriber's Name: _____

Subscriber's Relationship to Patient: _____

Subscriber's Address: _____

City: _____ State: _____ Zip: _____

Subscriber's SSN or ID#: _____

Insurance Company Name: _____

Insurance Address: _____

City: _____ State: _____ Zip: _____

SECONDARY INSURANCE TO FILE

Policy#: _____ Group#/Group Name: _____

Subscriber Date of Birth: _____ Subscriber's Name: _____

Subscriber's Relationship to Patient: _____

Subscriber's Address: _____

City: _____ State: _____ Zip: _____

Subscriber's SSN or ID#: _____

Insurance Company Name: _____

Insurance Address: _____

City: _____ State: _____ Zip: _____

Patient Name: _____ DOB: _____

PATIENT EMPLOYER/SCHOOL INFORMATION

Employer/School: _____ **Occupation:** _____

Employer/School Address: _____

Employer/School Phone Number: _____ **Employment Status:** ☐ Full Time ☐ Part Time

ADDITIONAL GENERAL INFORMATION
(ONLY FOR THOSE PATIENTS 18 YEARS OLD OR YOUNGER)

Father's Name: _____ **Contact Phone Number:** _____

Mother's Name: _____ **Contact Phone Number:** _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____ and assign directly to Harbison Medical Associates all medical benefits, if any, otherwise payable to me for services rendered understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions. _____ *(initials)*

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Harbison Medical Associates for any services furnished to me by that group. I authorize the release of medical information needed to determine these benefits. My signature below authorizes payment to be made directly to Harbison Medical Associates and if other health insurance is in effect as a supplemental policy. I further authorize payment to Harbison Medical Associates and also authorize the release of information to that company for payment of benefits. _____ *(initials)*

TREATMENT AUTHORIZATION

I authorize physicians, nurse practitioners and/or physician assistants of Harbison Medical Associates who may attend me, their assistants, including those employed by Harbison Medical Associates to provide the medical care, tests, procedures, drugs, blood and blood products, services and supplies considered advisable by my provider. These services may include pathology, radiology, emergency services and other special services ordered by my provider. In consenting to treatment, I have not relied on any statements as to results. I further authorize my provider to examine, use, store, and/or dispose of in any manner (except for organ donation and/or transplantation) any tissue, fluids or parts removed from my body. In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substance that are capable of transmitting disease and I am unable to consult timely with my physician prior to testing, I consent to limited testing to determine the presence, if any, of antibodies to hepatitis A, B, and C and HIV. _____ *(initials)*

HIPAA – Notice of Privacy Practices Acknowledgment

Your signature below acknowledges that **YOU** were made available the **Harbison Medical Associates Notice of Privacy Practices** that provides a description of information uses and disclosure practices. **YOU** accept and understand that **YOU**:

- Have the right to review the **NOTICE** prior to signing this consent.
- Accept that the practice reserves the right to change the **NOTICE** and its information practices.
- Have the right to request restrictions on the use or disclosure of your health information to carry out treatment, payment, or healthcare operations and to correct error(s) in your record. The practice, however, is not required to agree to the restrictions requested.
- May revoke this consent in writing that **YOU** provide to the practice. The revocation does not apply to any uses of your information made by the practice in reliance upon this consent form and on the belief that your consent was still effective. Initials of patient or person authorized to sign HIPAA Notice for patient _____ *(initials)*
- I agree and offer no objection to the verbal release of protected health information to the person(s) listed below. I also authorize them to pick up prescriptions, notes or other medical information on my behalf. _____ *(initials)*

Name	Relationship	Phone Number

- I authorize for detailed messages to be left on an at home machine. _____ *(initials)*
- I authorize for detailed messages to be left on a cellular device. _____ *(initials)*

IMMUNIZATION REGISTRY AND HEALTH INFORMATION EXCHANGE

It has been explained to me that LMC participates in an Immunization Registry and Health Information Exchange with the S.C. Department of Health and Environmental Control (DHEC). I understand this is a statewide, confidential database of patient immunization information and that my personal protected health information will be included in this database (please initial your preference from the 4 choices below):

☐ I hereby consent to **opt in/ participate in** and authorize the use of my health information in the **Immunization Registry** as deemed appropriate by my health care providers.

☐ I hereby wish to **opt out** of participation in the **Immunization Registry.**

☐ I hereby consent to **opt in/ participate in** and authorize the use of my health information in the **Health Information Exchange** as deemed appropriate by my health care providers.

☐ I hereby wish to **opt out** of participation in the **Health Information Exchange.**

I have read all parts of the patient information and authorization form supplied to me by Harbison Medical Associates, a Lexington Medical Center Physician Practice.

_____ _____

Patient/Guardian Signature Date

_____ _____

Print Name of Patient Date of Birth

Patient Name: _____ DOB: _____