LOWCOUNTRY LUNG™
AND CRITICAL CARE

(P): 843.572.3330
(F): 843.572.1255
lowcountrylung.com

PATIENT REGISTRATION FORM

Please Print Neatly and Legibly

Date: _____

Patient Information

_____ _____

Patient Social Security Number | Patient Primary Care Doctor

Patient Last Name | Patient First Name | Patient Middle Initial

Address | Apt. #

City | State | Zip Code

( ) - / /

Cell Phone Number | Date of Birth

Email Address | Employer

( )

Emergency Contact Name | Emergency Contact Phone number

Marital Status: (*Place an X beside your answer)*
_____ Single
_____Married
_____Widowed
_____Separated
_____Divorced
_____ Other
_____ Life Partner
_____ Divorced

Race: (*place an X beside your answer*)
_____ American Indian/ Alaskan Native
_____ Asian
_____ Black or African American
_____ White
_____ Multi-Racial
_____ Other
_____ Decline to Answer

Ethnicity: (*Place an X beside your answer*)
_____Hispanic or Latino _____Not Hispanic or Latino _____Other _____Decline to Answer

Insurance Information

Primary Insurance	Secondary Insurance
Who referred you to Lowcountry Lung	Pharmacy Name and Phone Number
Patient Signature	Date

Disclosure to Family Members and Friends

I _____ authorize Lowcountry Lung and Critical Care to disclose/discuss my private information relating to my health or for payment of healthcare services to those listed below, if needed. I understand that only information relevant to my current treatment will be disclosed. I have agreed that Lowcountry Lung and Critical care my disclose my current health information to:

Name (living family/friends only)	Relationship

Patient Signature Date

Cancellation Policy

Please be courteous and call promptly if you are unable to attend an appointment. This time will be given to someone in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call 24 business hours in advance. Appointments are in high demand, and your early cancellation will give another patient the opportunity to have access to timely medical care. Change in appointment by reschedule or cancellation with less than 24 hours notice will be considered a "No Show."

No Show Policy

A "No Show" is a patient who misses an appointment without canceling within 24 hours prior to the scheduled appointment. Patients will be allotted one, No Charge, "No Show" per calendar year. This "No Show" will be documented in your chart. If a patient has a second "No Show" in a calendar year, the patient will be required to pay $50.00 to be placed back on the schedule. A third "No Show" within in a calendar year will result in your account being placed on hold and will be reviewed by the Administrator and Medical Practice Partners as to whether we continue as your Pulmonary Care Provider.

Office/ Financial Policy

1. All payments for your medical services are due at the time of service. Expect to pay your co-payment, any remaining deductibles, or the percentage specified in your insurance contract at the time of service. Please know that it is unlawful to routinely waive, fail to collect or discount copays, deductibles, coinsurance or other patient responsibility payments per the Federal False Claims Act, Federal Anti-Kickback Statute, HIPAA and state and federal insurance fraud laws. It is also a violation of our managed care contracts with your insurance companies. The amount of your COPAY/COINSURANCE/DEDUCTIBLE is based on your insurance policy benefits.
2. If you have no insurance, or an extremely large deductible, please notify our staff right away. We will work with you to arrange a payment schedule if you inform us of the circumstances up front.
3. If your insurance has not paid within 90 days of our filing, the bill becomes your responsibility in full.
4. There is a $40.00 charge for returned checks.
5. THERE IS A CHARGE OF $25.00 FOR COMPLETION OF FORMS, OR LETTERS DICTATED BY A PHYSICIAN (DISABILITY, INSURANCE, SOCIAL SECURITY, FMLA AND MEDICAL RECORDS)
6. It is solely your responsibility to get authorization and referrals and to know the limitations of your insurance benefits.
7. If a test is not covered by your insurance, it will become the financial responsibility of the patient.

Assignment and Release

In order to ensure proper follow-up and continuity of care, I agree that copies of my medical records may be released to my physician(s) I may be referred to and/or the provider who referred me to this practice. I request that payment of authorized benefits be made Lowcountry Lung and Critical Care and/or its doctors on my behalf for any services provided to me. I authorize any holder of medical and other information about me to release to Medicare and its agents, any insurance company, any other third party payer, state medical assistance agency, or any other government or private payer responsible for paying such benefits, any information needed to determine these benefits or benefits for related services. I agree to pay for all charges not covered by a third-party payer. I authorize a copy of this authorization to be used in the place of the original, I authorize the use of this signature on all insurance submissions.

I have been read and understand the Cancellation, No Show, Office/Financial, Assignment and Release policies referenced above.

Signature Printed Name Date

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Medical Records Release Form

Please include any information including diagnosis and records of any treatment or examination rendered to me.

Name of Practice

Address

Fax Number

I hereby authorize you to release my medical records to the following Lowcountry Lung Office:

____**North Charleston Office** 9150 Medcom Street, North Charleston, SC 29406 (P) 843-572-3330 (F) 843-572-1255

____**West Ashley Office** 1938 Charlie Hall Blvd Unit A, Charleston, SC 29414 (P) 843-763-3360 (F) 843-763-3038

____ **Berkeley Office** 300 Callen Blvd Ste 240 Summerville, SC 29486 (P) 843-572-3330 (F) 843-572-1255

Patient Signature Patient Printed Name Date