Patient Registration Form

Patient Name: _____ **SSN:** _____

Date of Birth: ___/___/___ **Sex:** M / F **Marital Status:** Single / Married / Divorced / Widowed

Address: _____
(Street) (City/State/Zip)

Home Phone: _____ Mobile: _____ Work: _____

Email: _____ **Would you like to be set up on our Patient Portal? Y / N**

Employment: ___Full Time ___Part Time ___Self ___Retired ___Student ___Unemployed

Employer: _____

Who to call for an emergency:

Name: _____ Address: _____

Phone Number: _____ Relationship: _____

Primary Insurance Information: (please present your insurance card for our staff to copy)

Plan Name: _____ Address: _____

ID Number: _____ Group Number: _____

Policy Holder: _____ DOB: ___/___/___ SSN: _____

Secondary Insurance Information: (please present your insurance card for our staff to copy)

Plan Name: _____ Address: _____

ID Number: _____ Group Number: _____

Policy Holder: _____ DOB: ___/___/___ SSN: _____

Pharmacy Name: _____ **Pharmacy Phone:** _____

Pharmacy Address: _____

The Providers at Surgical Associates of Myrtle Beach use an electronic medical record system that allows electronic prescribing of medications. Medications are sent to your pharmacy through a secure electronic prescription connection (Rx Hub) which improves the timely and accurate transmission of your medication information. To optimize the use of this electronic capability, and coordinate your care between us and other specialists, we ask that patients allow us to access their medication history through the Rx Hub.

Please check only ONE of the following:

☐ **I CONSENT** to allow my provider to access all of my medication history.

☐ **I DO NOT** consent to my provider accessing any of my medication history.

Referring Physician: _____ **Primary Care Doctor:** _____

Reason for Visit: _____

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1. **I authorize the release of any medical information necessary to process claims to my insurance company and medical providers/facility, and request payment to Surgical Associates of MB. I acknowledge that I am financially responsible for payment whether covered by insurance or not. _____**
2. **I authorize the receipt of my medical records to Surgical Associates of MB from other medical providers/facilities. _____**
3. **I have read and understand the financial policy of Surgical Associates of MB and wish to have services provided to me. _____**
4. **I understand that if I NO SHOW to ANY appointment there will be a $50.00 charge to my account. _____**

(Please initial each line above)

Signature of patient/Responsible party: _____ **Date:** ___/___/___

Medical History

Patient Name:_____ **DOB:**___/___/___

Personal History

Height:_____ Weight:_____

Tobacco History? Current Smoker Former Smoker Never Smoked How much per day?_____

Alcohol History? Current Drinker Former Drinker Never Drank How much per day?_____

Do you drink coffee, tea, or soda? Y / N How much per day?_____

Current Medications and Dosages/ If none, check here **(You may attach a list)**

Medication	Dosage	Frequency

Allergies to Medications/ If none, check here _____

_____

Previous Surgeries/ If none, check here _____

_____

Please check all that apply:

Eye Problems	**Y**	**N**	**Neurological**	**Y**	**N**
Glasses			Seizures		
Contacts			Stroke		
Cataracts			TIA		
Glaucoma			Frequent Severe Headaches		
Recent Vision Changes			Neuropathy		
Ear Problems	**Y**	**N**	**Skin Disorders**	**Y**	**N**
Hard of Hearing			Open Wounds		
Hearing Aid			Rash		
Ringing in Ears			Cellulitis		
Ear Pain			Abscess		
Neck Problems	**Y**	**N**	Other:		
Neck Pain			**Psyche**	**Y**	**N**
Lumps or Swelling of the Neck			Depression		
Other:			Anxiety		

Medical History

Patient Name: _____ **DOB:**___/___/___

Respiratory	Y	N	Gastrointestinal	Y	N
Asthma			Hiatal Hernia		
Bronchitis			Gallbladder Disease		
COPD			Gastric Ulcers		
Emphysema			Grohn's Disease		
Cardiac	**Y**	**N**	Irritable Bowel Syndrome		
Heart Attack			Reflux		
Heart Disease			Weight Gain		
Irregular Heartbeat			Weight Loss		
Hypertension			Blood in Stool		
Congestive Heart Failure			Diverticular Disease		
Defibrillator			**Genitourinary**	**Y**	**N**
Pacemaker			Kidney Disease		
Atrial Fibrillation (AFIB)			Kidney Stones		
Swelling of Ankles and/or Feet			Kidney Infection		
Heart Murmur			Prostate Problems		
Valve Replacement			**Blood, Lymph, Liver Disease**	**Y**	**N**
High Cholesterol			Hepatitis A		
Peripheral Vascular	**Y**	**N**	Hepatitis B		
Leg Pain When Walking			Hepatitis C		
Cold and/or Numb Feet			HIV		
Change in Foot Color			Cirrhosis		
Varicose Veins			Clotting Disorder		
Aneurysm			Jaundice		
Carotid Bruits			Lymphedema		
Cancer	**Y**	**N**	**Endocrine**	**Y**	**N**
Colon/Rectal			Diabetes Type 1		
Breast			Diabetes Type 2		
Ovarian			Thyroid Disease		
Prostate			Lupus		
Other:			**Musculoskeletal**	**Y**	**N**
Other	**Y**	**N**	Back Problems		
Pregnant (If Applicable)			Rheumatoid Arthritis		
Flu Shot?			Osteoarthritis		
If so, when?			Fibromyalgia		
If no, are you planning to?			Joint Replacement		

Medical History

Patient Name:_____ **DOB:**___/___/___

Family History

If any **blood relative** has suffered from any of the following, please notate:

Condition	Relationship to You	Alive or Deceased	Cause of Death
Alcoholism		**A / D**	
Bleeds Easily		**A / D**	
Colon Cancer		**A / D**	
Ovarian Cancer		**A / D**	
Breast Cancer		**A / D**	
Diabetes		**A / D**	
Hypertension		**A / D**	
Heart Disease		**A / D**	
Stroke		**A / D**	
PVD		**A / D**	
Diverticular Disease		**A / D**	
Other:_____		**A / D**	

Signature of patient/Responsible party:_____ **Date:**___/___/___

Surgical Associates of Myrtle Beach | **Borowicz Vascular PC**

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

Phone Number:_____ **Email Address**:_____

Pharmacy Name:_____

Pharmacy Address:_____

Any New Medications or Recent Surgeries?

_____

_____

_____

_____

Vaccinations:

Covid-19: (Y / N) If yes, date received:_____

Flu: (Y / N) If yes, date received:_____

Pneumonia: (Y / N) If yes, date received:_____

Recent Labs/Imaging:

Colonoscopy: (Y / N) If yes, date performed:_____

Location performed:_____

Mammogram: (Y / N) If yes, date performed:_____

Location performed:_____

Surgical Associates of Myrtle Beach

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Dr. Lane I. Moore, M.D., F.A.C.S.

Breast and General Surgery

845 82nd Parkway
Myrtle Beach, SC 29572

Phone: (843) 449 - 9621
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Borowicz Vascular PC

Dr. Mark R. Borowicz, M.D., F.A.C.S.

General and Vascular Surgery

4036-2B River Oaks Drive
Myrtle Beach, SC 29579

Phone: (843) 449 - 3333
Fax: (843) 796 - 2376

Date:_____

Patient:_____ **DOB:**_____

I authorize my medical records and any medical information necessary to be released and obtained by Surgical Associates of Myrtle Beach to assist in the improvement of my quality of health. I have read and understand the medical release policy of Surgical Associates of Myrtle Beach and agree to the above.

_____ _____

Patient's Signature **Date**

_____ _____

Witness Signature (SAMB Employee Only) Date

Surgical Associates of Myrtle Beach | **Borowicz Vascular PC**

Authorization for Release of Information to Family and/or Friends

Patient: _____ **Date:** _____

Surgical Associates of Myrtle Beach is authorized to release protected health information about above-named patient to the authorized people named below:

Print Name	**Relationship/Phone Number**	**Please circle the information each person may receive:**
_____		**Clinical Appointment Financial**
_____		**Clinical Appointment Financial**
_____		**Clinical Appointment Financial**

Rights of Patient

I understand that I have the right to revoke this authorization at any time by contacting Surgical Associates of Myrtle Beach, and that I have the right to inspect or copy the protected health information to be disclosed as described in the document. I understand that a revocation is not effective in cases where the 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 and 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.

This authorization shall be effective until revoked by the patient or the patient's representative.

_____ _____

Signature of Patient or Personal Representative | Date

_____ _____

SAMB Employee | Date

Medical History

(Dr. Moore and Dr. Nicholson Patients Only)

Patient Name:_____ **DOB:**___/___/___ **Age:**_____

1. **Previous Breast Masses?** Yes_____ No_____

2. **Hormone use: (i.e.)** Provera_____ Premarin_____
   Birth Control Pills_____

3. **Family History of Breast Cancer?** Yes_____ No_____
   Mother_____
   Sister_____
   Cousin_____
   Aunt_____

4. **Previous Breast Biopsies?** Yes_____ No_____
   When?_____
   Which Breast?_____

5. **Previous Mammograms?** Yes_____ No_____
   When?_____ Where?_____

6. **Onset of Menses?** Year_____ Age_____
   (First Menstrual Period)

7. **Menopause?** Year_____
   ("Change in Life") (If Applicable)

8. **Last Menstrual Period?** Date_____

9. **Hysterectomy?** Yes_____ No_____
   If yes, were the ovaries removed?_____

10. **Do you have children?** Yes_____ No_____
    Were your children breast fed? Yes_____ No_____

11. **What is the age of your oldest child?**_____

12. **Are you having any nipple discharge?**_____

13. **Do you practice self-breast examinations?** Yes_____ No_____
    Monthly?_____
    Occasionally?_____

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HIPAA Policy

Notice of Privacy Practices for Protected Health Information
45 CFR 164.512

Background

The HIPAA Privacy Rule gives individuals a fundamental new right to be informed of the privacy practices of their health care providers, as well as to be informed of their privacy rights with respect to their personal health information. Health plans and covered health care providers are required to develop and distribute a notice that provides a clear explanation of these rights and practices. The notice is intended to focus individuals on privacy issues and concerns, and to prompt them to have discussions with their health plans and health care providers and exercise their rights.

How the Rule Works

The Privacy Rule provides that an individual has a right to adequate notice of how a covered entity may use and disclose protected health information about the individual, as well as his/her rights and covered entity's obligations with respect to that information. Most covered entities must develop and provide individuals with this notice of their privacy practices. The Privacy Rule does not require the following covered entities to develop a notice:

- Healthcare Clearinghouses, if the only protected health information they create or receive is a business associate of another covered entity. See CFR 164.5(b)(1).
- A correctional institution that is a covered entity (e.g., that has a covered health care provider component)
- A group health plan that provides benefits only through one or more contracts of insurance with health insurance issuers or HMOs, and that does not create or receive protected health information other than summary health information or enrollment or disenrollment information. See 45 CFR 164.520(a)

Covered entities are required to provide a notice in plain language that describes:

- How the covered entity may use and disclose protected health information about an individual.

- The individual's rights with respect to the information and how the individual may exercise these rights, including how the individual may complain to the covered entity.
- The covered entity's legal duties with respect to the information, including a statement that the covered entity is required by law to maintain the privacy of protected health information.
- Whom individuals can contact for further information about the covered entity's privacy policy.

The notice must include an effective date. See 45 CFR 164.520(b) for the specific requirements for developing the content of the notice. A covered entity is required to promptly revise and distribute its notice whenever it makes material changes to any of its privacy practices. See 45 CFR 164.520(b)(3), 164.520(c)(1)(i)(C) for health plans, and 164.520(c)(2)(iv) for covered health care providers with direct treatment relationships with individuals.

Providing the Notice:

- A covered entity must make its notice available to any person who asks for it.
- A covered entity must prominently post and make available its notice on any website it maintains that provides information about its customer services or benefits.

Health Plans must:

- Provide the notice to individuals then covered by the plan and to new enrollees at the time of enrollment.
- Provide a revised notice to individuals, then covered by the plan within 60 days of material revision.
- Notify individuals then covered by the plan of the availability of and how to obtain the notice at least once every three years.

Covered Direct Treatment Providers must:

- Provide the notice to the individual no later than the date of first service delivery and, except in an emergency treatment situation, make a good faith effort to obtain the individual's written acknowledgement of receipt of the notice. If an acknowledgement cannot be obtained, the provider must document his/her efforts to obtain the acknowledgement and the reason why it was not obtained.
- When first service delivery to an individual is provided over the internet, through email, or otherwise electronically, the provider must send an electronic notice automatically and contemporaneously in response to the individual's first request for service. The provider must make a good faith effort to obtain a return receipt or other transmission from the individual in response to receiving the notice.

- In an emergency treatment situation, provide the notice as soon as it is reasonably practicable to do so after the emergency situation has ended. In these situations, providers are not required to make a good faith effort to obtain a written acknowledgement from individuals.
- Make the latest notice (i.e., the one that reflects any changes in privacy policies) available at the provider's office or facility for individuals to request to take with them, and post it in a clear and prominent location at the facility.

A covered entity may email the notice to an individual if the individual agrees to receive and electronic notice. See 45 CFR 164.520(c) for the specific requirements for providing the notice

Organizational Options:

- Any covered entity, including a hybrid entity or and affiliated covered entity, may choose to develop more than one notice, such as when an entity performs different types of covered functions (i.e., the functions that make it a health plan, a health care provider, or a health care clearinghouse) and there are variations in its privacy practices among these covered functions. Covered entities are encouraged to provide individuals with the most specific notice possible.
- Covered entities that participate in an organized health care arrangement may choose to produce a single, joint notice if certain requirements are met. For example, the joint notice must describe the covered entities ant the service of delivery sites to which it applies. If any one of the participating covered entities provides the joint notice to an individual, the notice distribution requirement with respect to that individual is met for all of the covered entities. See 45 CFR 164.520(d).

Patient Signature _____ Date _____

If you have any questions regarding this notice, please contact Surgical Associates of Myrtle Beach's Office Manager at 843-449-9621.

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Patient Financial Policy and Agreement

Surgical Associates of Myrtle Beach (SAMB) believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

1. INSURANCE is a contract between you and your insurance company. It is your responsibility to understand your benefit plan with regard to covered services, participating physicians and facilities, referrals, and prior authorizations for services; as well as to provide us with complete and accurate insurance information at the time of your appointment. We will bill your insurance company as a courtesy to you, but failure to provide proper insurance information may result in patient responsibility for your visit.

   Our staff will verify your insurance benefits and obtain authorizations prior to your appointment; however, this is not a guarantee of payment. Payments of benefits are subject to all terms, conditions, limitations and exclusions of your insurance contract at the time of service. If your insurance company denies coverage for any reason you will be fully and personally responsible for payment to SAMB.

2. PAYMENT is expected at the time of check-in for your visit. According to your insurance plan, you are responsible for any unmet deductible, co-insurance, co-payment amount, or charges not covered by your insurance company. If you are responsible for any remaining balance on your account after your insurance has been processed. If you do not carry insurance, payment in full is expected at the time of your visit. We gladly accept cash, checks, or credit/debit cards.

3. LATE CHARGES of 18% annually will be applied to all patient balances 60 days old or greater.

4. RETURNED CHECKS will incur a $50.00 service charge that will be added to your outstanding balance, and must be paid prior to receiving additional services from our staff or the physician.

5. FORM FEES: Completing forms for insurance, FMLA, disability, employers and attorneys are subject to a $25.00 fee. Postage is additional and payment is required in advance. SAMB will

Insurance Terms to Understand:

Premium:	**The amount you pay monthly for your health insurance.**
Deductible:	**The amount you pay out of pocket before your insurance starts paying. For instance, if you have a $500.00 deductible, you will pay for most of your healthcare expenses until you have spent $500.00. At that point, your insurance starts paying a portion of all of your costs.**
Co-pay:	**A small fee you pay each time you use a specific service. This fee does not go towards meeting your deductible.**
Co-insurance:	**Some plans have you pay a percentage of your expenses after your deductible is met.**

PLEASE NOTE: You have a binding contract with your insurance company to pay these fees at the time of service, and we have a contractual obligation to collect them. It is a breach of these contracts not to do so.

have 15 business days in which to complete all forms. Authorization to release medical information must accompany forms or be on file with SAMB.

6. CANCELLATIONS OR MISSED APPOINTMENTS: If you do not cancel your appointment at least 24-hours before, or if you no-show, we will assess a $50.00 missed appointment fee.

7. RESPONSIBILITY FOR A PAYMENT: The patient is fully and financially responsible to SAMB for charges not covered by the assignment of insurance benefits.

8. COLLECTION FEES: In the event your account is placed in collections status, any additional fees incurred due to this will be added to your outstanding balance. This includes but is not limited to late fees, collections agency fees, court costs, interest and fines. These additional fees will be your personal responsibility to pay in full.

9. BILLING OFFICE: If you have questions in regard to any of your billing statements, please contact Associated Billing Services at 877-422-7462.

Assignment of Insurance Benefits: I hereby authorize direct payment of medical benefits to Surgical Associates of Myrtle Beach (SAMB) for services provided. I authorize SAMB to contact my insurance company or health plan administrator to obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to SAMB. I authorize SAMB to release all medical information requested by my health insurance carrier, Medicare, or other physicians or providers, and any other third-party payers.

Release of Information: I authorize the release of any medical information necessary to obtain payment. I understand that I am financially responsible for all charges, late fees, interest, attorney fees and collections charges - if applicable - that are considered patient responsibility by my insurance company. I understand that if I am not insured, I am responsible for the charges of all services provided to me.

I have read and understand the practice's financial policy, I agree to be bound by its terms, and I accept responsibility for any fees associated with my care.

_____ _____

Signature of Patient (or Guarantor, if applicable) **Date**

_____

Please print the name of the patient

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Patient Rights and Responsibilities

We at Surgical Associates of Myrtle Beach believe the protection and support of the basic human rights of freedom of expression, decision and action are important to the healing and well-being of our patients. We strive to treat all patients with respect and with full recognition of human dignity. Decisions regarding all health care will not be based on race, creed, sex, national origin, age, disability, or source of payment.

1. Patients have the right to have their treatment and other patient information kept private. Only where permitted by law, may records be released without patient permission.
2. Patients have the right to reasonable response to your request and need for treatment or service, within our capacity and applicable laws and regulations.
3. Patients have the right to information necessary for them to make informed decisions, in consultation with their physician, about their medical care including information about their diagnosis, the proposed care and their prognosis in terms and a manner that you can understand before the start of their care. You also have the right to take part in the development and carrying out the plan of care.
4. Patients have the right to consent to or refuse medical care, to the extent permitted by law, and to be told the risks of not having the treatment or treatments which are available.
5. Patients have the right to have information about their insurance, its practitioners, services and role in the treatment process.
6. Patients have the right to clinical guidelines used in providing and managing their care.
7. Patients have the right to change their provider to any other available provider.
8. Patients have the responsibility to provide accurate and complete information to the best of their ability about their health, any medications taken (including over-the-counter products and dietary supplements), and any allergies or sensitivities.
9. Patients are responsible for following recommended treatment(s).
10. Patients are responsible for providing a responsible adult to provide transportation home and to remain with them as directed by the provider or as indicated in discharge instructions.
11. Patients are responsible for promptly fulfilling the financial obligations of health care.

12. Patients have the responsibility to let their provider know when their treatment plan is not working for them.
13. Patients have the responsibility to keep their appointments. Patients should call their provider as soon as they know they need to cancel their visit.
14. Patients have the responsibility to tell their provider and their primary care provider about medication changes; including medications given to them by others.
15. Patients have the right to freely file a complaint or appeal and to learn how to do so with their insurance company.
16. Patients have the responsibility to openly report concerns about the quality of care they receive.
17. Patients have the responsibility to be considerate of other patients and staff.
18. Patients and visitors are responsible for their belongings.

Patient Signature

Date