# PLEASURE ISLAND HEALTH – PAPERWORK

**Patient Information**

Patient Name_______________________________________________DOB_________________ Sex____________
Last First M.

Drivers License_______________Social Security Number_____/____/_____Email______________________________

Home Phone________________________________________Cell Phone____________________________________

Address_______________________________________________________________________________________
Street City State Zip Code

**Emergency Contact**

Emergency Contact____________________________________Relationship________________________________

Home Phone________________________________________Cell Phone___________________________________

**Insurance**

Insurance Company________________________________________ Phone Number__________________________

Subscriber's Name ______________________Relationship__________Subscriber's DOB___/___/___SS#___/__/____
If different from patient

Policy Number_____________________________________Group________________________________________

Subscriber's Name _____________________Relationship t_________Subscriber's DOB___/___/____ SS#___/__/____
If different from patient

Secondary Insurance Company__________________________________________________________________

Policy Number_____________________________________Group________________________________________

**Primary Care Physician (REQUIRED)**______________________________________________________________
**Physician First Name** **Physician Last Name**

______________________________________________________________________________________________
**Practice Name/Address** **City** **State**

**Please Initial and sign below.**

_____By signing this form, I am granting permission to Pleasure Island Health to release medical information, including encounter notes, radiology, lab results, or any other information deemed necessary to coordinate my care with my referring and/or Primary Care Physician.

_____Furthermore, I consent that this release is in effect, until I state in writing that I wish for it to be revoked.

I verify that the above information is factual and true to the best of my knowledge. I understand that payment, proof if insurance, and /or copay is due at time of service. I authorize this office to apply benefits on my behalf for the covered services rendered. I certify that the insurance information I have provided is factual and correct.

Print name__________________________________Signature___________________________Date_____________

# PATIENT HEALTH HISTORY

Patient Name______________________________________________DOB____________

**Describe your symptoms:**

**When did symptoms start?**

## Current Medications

***Check Box & list medication name**

- ☐ Anxiety: ____________________
- ☐ Asthma:____________________
- ☐ Birth Control:_______________
- ☐ Blood Pressure:______________
- ☐ Blood Thinners: ____________
- ☐ Cholesterol: ________________
- ☐ Depression: ________________
- ☐ Diabetes ___________________
- ☐ Pain: _____________________
- ☐ Stomach: __________________
- ☐ Other: ____________________

## Allergies

- ☐ Aspirin
- ☐ Ibuprofen
- ☐ Sulfa
- ☐ Codeine
- ☐ Penicillin
- ☐ Latex
- ☐ Other:__________

_______________

_______________

## Social History

| **Circle** One | | | **Description** | **Amount** |
|---|---|---|---|---|
| Caffeine | Yes | No | ____________________ | ______ |
| Tobacco | Yes | No | ____________________ | ______ |
| Alcohol | Yes | No | ____________________ | ______ |
| Drugs | Yes | No | ____________________ | ______ |
| Steroids | Yes | No | ____________________ | ______ |

**Marital Status: (circle one)**

Married Single Divorced Widowed Separated

**Employment: (circle one)**

Employed Unemployed Retired Disabled

## Surgeries

*List all surgeries:*

| | | |
|---|---|---|
| ☐ *Appendix* | ☐ *Carpel Tunnel* | ☐ *Endoscopy* |
| ☐ *Gall Bladder* | ☐ *Heart* | ☐ *Hernia* |
| ☐ *Hysterectomy* | ☐ *Knee* | ☐ *Tonsils* |
| ☐ *Tubal Ligation* | ☐ *Tubes in Ears* | ☐ *Spine* |

☐ *Other:* ________________________________________

*Surgery*______________________________*Date*__________

*Surgery*______________________________*Date*__________

## Past Medical History (Check all that apply)

| | | | | |
|---|---|---|---|---|
| ☐ *Diabetes* | ☐ *High Blood Pressure* | ☐ *High Cholesterol* | ☐ *Hypothyroidism* | ☐ *Goiter* |
| ☐ *Cancer: Type*________ | ☐ *Leukemia* | ☐ *Psoriasis* | ☐ *Angina* | ☐ *Heart Problems* |
| ☐ *Heart Murmur* | ☐ *Pneumonia* | ☐ *Pulmonary Embolism* | ☐ *Asthma* | ☐ *Emphysema* |
| ☐ *Stroke* | ☐ *Epilepsy (Seizures)* | ☐ *Cataracts* | ☐ *Kidney Failure* | ☐ *Kidney Stones* |
| ☐ *Crohn's Disease* | ☐ *Colitis* | ☐ *Anemia* | ☐ *Jaundice* | ☐ *Hepatitis* |
| ☐ *Stomach / Peptic Ulcer* | ☐ *Rheumatic Fever* | ☐ *Tuberculosis* | ☐ *HIV/AIDS* | ☐ *Liver Disease* |
| ☐ *Depression* | ☐ *Anxiety* | | | |

## Family History

*Any immediate family history of the following:*

| | | |
|---|---|---|
| Cancer: | Yes | No |
| Diabetes: | Yes | No |
| High Blood Pressure | Yes | No |
| Asthma | Yes | No |

## Signature

**I certify that the information on this page is true and accurately reflects the medical history for me or my child/ward.**

**✕ ___________________________________Date___________**

# Consent for Treatment and Release of Information

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that

1. you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and
2. you consent to treatment at this office. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your provider about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a health care provider, or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

Acting on my own behalf or on behalf of my child/ ward, and suffering from a condition requiring medical care, I hereby consent to the rendering of such care, which may include routine diagnostic procedures and such medical treatment as the medical staff of Pleasure Island Health consider to be necessary. I understand that, absent emergency or extraordinary circumstances, if further consent for tests or treatments is necessary and warranted by the condition of me or my child/ward, the procedure(s) will be explained to me by the provider or his/her representative as appropriate, and further consent sought from me at that time.

Patient Name______________________________________________________________Date____________
Print Name Signature

Witness Name______________________________________________________________Date____________
Print Name Signature

# Financial Agreement

**Thank you for choosing Pleasure Island Health care provider!** We are committed to providing you with quality and affordable health care when you need it. We ask all patients to review and sign this policy, asking questions as necessary. A copy can be provided upon request.

**Insurance:** We participate with several insurance plans. If your insurance is not a plan we participate with, payment in full is expected at the time of your visit.

- **We accept:** Medicare, Medicaid, Blue Cross Blue Shield, Unites Health Care, Cigna. Humana, Aetna, Med-Cost, Magnacare, Cigna, TriCare, Most Workers Compensation

**Patient payment:** All copayments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. If you have questions, please contact your insurance company directly.

***PLEASE NOTE:* We do our very best to determine the copay, deductible, or coinsurance you may owe at the time of your visit. However, sometimes we are not provided accurate information regarding your financial responsibility when we verify your insurance through your carrier's website or by phone with your carrier. If an unmet deductible, or other financial responsibility is not accurately communicated to us at your time of service, any balance remaining after your claim has processed is your responsibility.**

**Registration:** All patients must complete our patient intake forms, which will be entered into our computer to maintain accurate information for proper billing. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information, or your insurance changes and you fail to notify us in a timely manner, you may be responsible for the balance of a claim.

**Claims:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Please be aware that the balance of your claim is your responsibility whether your insurance company pays or not. Your insurance benefit is a contract between you and the insurance company; we are not party to that contract.

**Uninsured patients:** We offer a "Self-Pay" option to our patients to pay "out of pocket" if they do not have insurance, or are insured with United Health Care, Cigna, or BCBSNC, or other out-of-network insurances.

| | |
|---|---|
| Same Day Sick Visit<br>(Cold, Flu, etc..) | $75 |
| Sports Physical | $39 |
| Employer UDS | $49 |
| Immediate Care Varies depending on diagnosis & treatment<br>***You may have additional cost for treatments such as ear irrigation, foreign body removal, laceration repair, wound care, or if you need sutures, etc. We will do our very best to let you know up front the approximate cost of your treatment*** | Starting at<br>$104.68 |

# HIPAA PATIENT CONSENT AND ACKNOWLEDGEMENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.  The patient acknowledges that he/she has received a copy of our HIPAA practices brochure.

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices for Pleasure Island Health, PLLC.

**The Consent was signed by:**

Patient Name__________________________________________________________Date___________
Print Name Signature

Witness Name_________________________________________________________Date___________
Print Name Signature

If person signing is not the patient, please print your name and relationship to patient:

Name ________________________________________________________________________

Relationship _________________________________________________________________

**For Office Use:** Did patient or representative request a copy of the Notice of Privacy Practices? Yes ___ No ___
If patient/representative requested copy of Notice, date copy was provided: ______________________________

# Medical Information Release Form (HIPAA Release Form)

**Name: _______________________________Date of Birth: ___/___/____**

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information.

**This information may be released to:**

[ ] Spouse (Name)__________________________________

[ ] Child(ren) (Name)________________________________

[ ] Other (Name) ___________________________________

[ ] Information is not to be released to anyone

This Release of Information will remain in effect until terminated by me in writing.

**For Voice Mail Messages – Please call**

[ ] my home____________ [ ] my work_____________[ ] my cell______________

**If unable to reach me:**

[ ] You may leave a detailed message

[ ] Please leave a message asking me to return your call

**YOU MUST CHECK ONE OF THE BOXES BELOW:**

☐ I AUTHORIZE ICE TO RELEASE MY MEDICAL RECORDS FOR TODAY'S VISIT TO MY CURRENT PCP.

☐ I DO NOT AUTHORIZE ICE TO RELEASE MY MEDICAL RECORDS FOR TODAY'S VISIT TO MY PCP.

______________________________________________________________

Signature of Patient (or parent/legal guardian if patient is a minor)
Date

______________________________________________________________

Signature Witness
Date