Date:______________

Patient Information

Patient Name (Last)____________________________ (First)_________________________ (MI)________

Preferred Name:___________________ Date of Birth_______________ Social Security Number___________________

Sex____________ Marital Status:____________ Patient Email:____

Address____City______________________ State________Zip__________

Home Phone ________________________Cell Phone ______________________Work Phone____________________

Race (Check One)
African American/Black
American Indian
Alaska Native
Asian Native Hawaiian/Pacific Islander
White
Other

Ethnicity (Circle One)
Hispanic or Latino
Not Hispanic or Latino

Occupation:_______________________________ Employer:____

Emergency Contact Full Name:________________________________ Phone:________________________________

Primary Insurance:____Policy#_______________________________________

Group:_______________________ Subscriber: _________________________________ DOB:____________________

Secondary Insurance:__________________________________Policy#____

Group:_______________________ Subscriber: _________________________________ DOB:____________________

PATIENT COMMUNICATION PREFERENCES

In our efforts to comply with the Health Insurance Portability and Accountability Act (HIPAA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and co-workers. You will be asked several questions that fall into HIPAA, please answer them to help us protect your privacy.

Do you authorize this office to mail correspondence to the address you have on file? YES☐ NO☐

Do you authorize this office to leave voice mail messages (Home answering machine/Cell phone) regarding your medical conditions, test results, medications, and appointments? YES☐ NO☐

Do you authorize this office to send text/SMS messages regarding your medical conditions, test results, medications, and appointments? YES☐ NO☐

Do you authorize this office to send emails regarding your medical conditions, test results, medications, and appointments? YES☐ NO☐

Do you want to use the immunization registry? YES☐ NO☐

Do you want to participate in immunization info sharing? YES☐ NO☐

Do you want to participate in health info exchange? YES☐ NO☐

Tobacco:

Do you currently use tobacco ? ☐ Yes ☐ No

Did you use tobacco in the past ? ☐ Yes ☐ No

How long: ___________

☐ Cigarettes ___/day ☐ Chew ___/day ☐ Cigars ___/day

Alcohol Intake:
☐ None ☐ Occasional ☐ Moderate ☐Heavy

Caffeine:
☐ None ☐ Occasional ☐ Moderate ☐Heavy
cups/cans per day ?___________

Drugs:
Do you currently use recreation or street drugs ? ☐ Yes ☐ No

Are you sexually active ? ☐ Yes ☐ No

Are you interested in being screened for STD's ? ☐ Yes ☐ No

Advanced Directive:
Do you have and Advanced Directive or Healthcare Proxy? ☐ Yes ☐ No

Colonoscopy or Cologuard:___________________

(WOMEN ONLY) OBSTETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear Date: _________________Last Mammogram Date: _________________________

Date of last menstrual period or menopause: ___________________Bone Density:______________________

Number of pregnancies: ____ Number of Births: ____

Vaccines:

Pneumonia:_______________ Flu: ____________________Covid: ___________________ TDAP:_____________

Other:_________________

PAST MEDICAL HISTORY

Have you ever been told you had one of the following? Please check Yes if have now or have had in the past.

	Yes	No		Yes	No		Yes	No
Allergies	☐	☐	Diabetes Mellitus Type 1	☐	☐	Lung Disease	☐	☐
Anemia	☐	☐	Diabetes Mellitus Type 2	☐	☐	Mental Illness	☐	☐
Anxiety	☐	☐	Diabetic Complications	☐	☐	Movement Disorder	☐	☐
Arthritis	☐	☐	Endocrine Disease	☐	☐	Nerve Disease	☐	☐
Asthma	☐	☐	Eye Problems	☐	☐	Osteopenia/Osteoporosis	☐	☐
Autoimmune Disease	☐	☐	Gastritis/Ulcer	☐	☐	Overweight/Obesity	☐	☐
Back/Neck Pain	☐	☐	GERD/Acid Reflux	☐	☐	Pneumonia	☐	☐
Blood Disorder	☐	☐	Headaches/Migraine	☐	☐	Prostate Disorder	☐	☐
Bowel Disease	☐	☐	Hearing Loss	☐	☐	Spine Disease	☐	☐
CAD	☐	☐	Heart Rhythm Disorder	☐	☐	Stroke/TIA	☐	☐
CHF	☐	☐	Heart Disease	☐	☐	Thyroid Disease	☐	☐
COPD	☐	☐	Hypertension	☐	☐	Tuberculosis/Pos PPD	☐	☐
Cancer	☐	☐	Hyperlipidemia	☐	☐	Urinary Problems	☐	☐
Dementia	☐	☐	Kidney Disease/Stones	☐	☐	Viral Disease	☐	☐
Developmental	☐	☐	Liver	☐	☐	Other:		
Depression	☐	☐						

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL
1.____________________	____________________	__________	________________
2.____________________	____________________	__________	________________
3.____________________	____________________	__________	________________
4.____________________	____________________	__________	________________

FAMILY HEALTH HISTORY

RELATION	SIGNIFICANT HEALTH PROBLEMS
1.____________________	____
2.____________________	____
3.____________________	____
4.____________________	____

Preferred Pharmacy____________________________ Location_________________________

Phone_______________

Alternate Pharmacy___________________________ Location_________________________

Phone________________

Allergies:____

MEDICATIONS

Name	Dosage	Direction

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: ___________________________________ Birth Date ______________________

Telephone No. _____________________________ Last 4 SSN: _________

Release From:
Name of Provider or Organization:____

Address:____

Phone:____________________________________ Fax:_____________________________

I AUTHORIZE YOU TO FURNISH RECORDS TO :

SYMBIOS MEDICAL SERVICES
460 William Hilton Parkway Hilton Head, S.C. 29926
Ph: 843-738-4800 Fax: 843-738-4801

The information that may be released ounder this Authorization includes:

☐ Discharge Summary ☐ Progress/Physician Notes ☐ X-Ray Report ☐ Pathology Report
☐ History & Physical ☐ Nurses Notes ☐ EKG/EMG/EEG Report ☐ Consult Report
☐ Emergency Report ☐ Laboratory Report ☐ Operative Report ☐ Entire Record
☐ Other____

Records for the period (dates) from __________________ to __________________

EXPIRATION OF AUTHORIZATION:
Unless otherwise revoked, this Authorization expires on ____________________ (insert applicable date or event). If no date indicated, this authorization will expire 12 months after the date of signed authorization below.

I UNDERSTAND that any disclosure of my personal health information may include information regarding diagnosis and/or treatment for any of the following: alcohol abuse, drug abuse, psychiatric or mental illness, and/or sexually transmitted diseases including Human Immunodeficiency Virus (HIV) or (AIDS virus). Symbios Medical Services is hereby released from all legal liability that may arise from the release of the information requested. Please note that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected under applicable federal HIPAA laws and regulations.

I UNDERSTAND that I may revoke this authorization at any time, with a written request to Symbios Medical Services. The request to revoke this authorization must contain the signature of the patient or the patient's legal representative. Revocation of this authorization is allowable only to the extent that the release of information has not already occurred and/or only if the facility has not acted in reliance thereon.

Signature:_____________________ __________________________________Date: __________________________

Printed name:____Relationship to patient: ________________________

HIPAA - NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your provider, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your provider's practice.

Following are examples of the types of uses and disclosures of your protected health information that your provider's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use or disclose medical information about you for treatment purposes to providers, nurses, technicians, and other caregivers in accordance with the "Authorization for Use & Disclosure or Protected Health Information" that you agreed to and provided to us. For example, your protected health information may be provided to a provider to whom you have been referred to ensure that the provider has the necessary information to diagnose and/or treat you.

Payment: We will use and disclose your medical information as necessary for payment purposes, in accordance with the "Authorization for Use & Disclosure or Protected Health Information" that you agreed to and provided to us. For instance, we may forward information regarding your medical treatment to your insurance company to arrange payment for the services provided to you or we may use your information to prepare a bill to send to you or to the person responsible for your payment.

Health Care Operations: We may use and disclose medical information about you to support our health care operations. For example, we may use or disclose your medical information in order for us to review our services and to evaluate our staff's performance. We may also use or disclose your medical information to obtain a medical consultation regarding your care or treatment

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include but are not limited to:

Required By Law	Food and Drug Administration	Public Health
Legal Proceedings	Communicable Diseases	Law Enforcement
Health Oversight	Research	Abuse or Neglect
Military Activity and National Security		

Unless you tell us otherwise, we may disclose your medical information to a family member, friend, and others whom you have identified as being involved with your care. If family members or friends are present while care is being provided, we will assume you are comfortable with your companions hearing the discussion, unless you state otherwise.

In any other situation not covered by this notice, we will ask for your written authorization before using or disclosing your medical information. If you choose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision.

2. YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Following is a list of your rights with respect to your Protected Health Information.

Inspect and copy your Protected Health Information
Request a restriction of your Protected Health Information
Request to receive confidential communications from us by reasonable alternative means or location Have your provider amend your Protected Health Information
Receive an accounting of certain disclosures we have made
Obtain a paper copy of this notice from us

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer at (843)738-4800 for further information about the complaint process. This notice was published at Symbios Medical Services and became effective on December 3, 2022.

INFORMED CONSENT FOR TELEMEDICINE

TELEMEDICINE APPOINTMENTS: Telemedicine involves the use of audio, video, or other electronic communications to interact with you, consult with your healthcare provider and/or review your medical information for the purpose of diagnosis, therapy, follow-up and/or education. During your telemedicine visit, details of your medical history and personal, health information may be discussed.

The benefits of telemedicine include having access to medical care without having to travel to the office. A potential risk is that because of specific medical conditions, or due to technical problems, a face-to-face visit still may be necessary after the telemedicine/telehealth appointment. Additionally, in rare circumstances, security protocols could fail causing a breach of patient privacy. The alternative to a telemedicine visit is a face-to-face visit with a provider.

All laws concerning patient access to medical records and copies of medical records apply to telemedicine. All existing confidentiality protections under federal law apply to information used or disclosed during your telemedicine visit.

You may withhold or withdraw your consent to a telemedicine visit at any time without it affecting your right to future care or treatment.

I have read and understand the information provided above regarding telemedicine and been given the opportunity to ask questions.

I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize Symbios Medical Services to use telemedicine in the course of my diagnosis and treatment.

____ _____________________________

Signature of Patient or Authorized Person Date

____

Printed Name

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGEMENT

A Notice of Privacy Practices (NPP) is provided to all patients. This Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information. amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information ; 3) your rights to complain if you believe your privacy rights have been violated; and 4) Our responsibilities for maintaining the privacy of your medical information.

Do you want a copy of the "HIPPA - Notices of Privacy Practices" made available to you? YES☐ NO☐

The undersigned certifies that he/she read the foregoing, was offered a copy of the Notice of Privacy Practices and is the patient, or the patient's personal representative.

________________________________	________________________________
Name of Patient	Signature of Patient/Date Signed
Name of Patient's Personal Representative	Signature of Patient's Personal Representative/ Date Signed

---

FOR INTERNAL USE ONLY

Name of Employee: ________________________________

Signature of Employee: ________________________________

If applicable, reason patient's written acknowledgment could not be obtained:

☐ Patient was unable to sign.

☐ Patient refused to sign.

Other:____

PHI DISCLOSURE TO FAMILY MEMBERS

You may authorize us to contact a family member or other designated person regarding your medical care or financial matters. You have the right to revoke this consent in writing except where we have already made disclosures in reliance on your prior consent.

This is to acknowledge that you authorize SYMBIOS MEDICAL SERVICES to disclose your PHI to the following individual(s)"

Name:________________________________ Relationship to Patient:_____________________

Telephone:(   )_____________________ Email:_____________________________________

Types of Information: ☐ Appointment Reminders ☐ Results (lab test, X-Ray, etc) ☐ Financial ☐ Other:

Okay to contact via: ☐ Telephone ☐ Leave a Voice Mail ☐ Patient Portal & Secure Email ☐ Other:

Name:________________________________ Relationship to Patient:_____________________

Telephone:(   )_____________________ Email:_____________________________________

Types of Information: ☐ Appointment Reminders ☐ Results (lab test, X-Ray, etc) ☐ Financial ☐ Other:

Okay to contact via: ☐ Telephone ☐ Leave a Voice Mail ☐ Patient Portal & Secure Email ☐ Other:

☐ None of the above

Signature: ______________________________________ Date: ______________________

Printed Name:____________________________________

Financial Policy and Consents

The following is an outline of financial responsibilities in relation to your care. Patients are expected to provide identification and if insured, a current copy of their insurance card(s). Patients are financially responsible for all services provided and are expected to pay at the time of service. If the patient is a minor child, the parent or accompanying adult will be financially responsible regardless of legal guardianship. Returned checks will be subject to fees.

Self-Pay: Patient is responsible for payment in full at the time of service for all services rendered.

Medicare: The office will bill Medicare for you. Patients will be responsible for the following:

1. Annual deductible
2. Applicable copays and/or co-insurance of the allowed charges
3. Any non-covered services
4. Any covered service ordered by the provider which does not meet medical necessity and Medicare beneficiary has signed an Advanced Beneficiary Notice. (ABN)

Commercial, PPO, and HMO Insurance Plans: All co-payments, co-insurance and/or deductible or non-covered amounts are due at the time of service. Insurance is filed as a courtesy and benefits are authorized to be paid directly to Symbios. Patients are responsible for the balance if not paid by the insurance within 30 days. If a patient is unable to pay their balance, the provider will determine if it is medically necessary for the patient to be seen. If the condition allows, the patient will be rescheduled.

Out of State Insurance: If an out of state HMO/PPO insurance card is presented, the practice will verify the patient's benefits for out of state or out of network benefits. The patient may be required to pay in full for services provided, any co-pay, co-insurance, or deductible.

Medicaid: Patients must provide a current card at each visit. Patients are responsible for applicable co-pays and all non-covered services.

Worker's Compensation: Employer authorization must be provided before services are rendered or the patient will be responsible for payment in full at the time of service. If the case is dismissed or denied, the patient will be responsible for the full amount.

Personal Injury/Motor Vehicle/Other Third Party: The patient is responsible for the balance in full at the time of service. Any settlement the patient receives form your insurance company or other third party will be handled by you, your insurance company, and your attorney.

ASSIGNMENT AND RELEASE: I hereby assign all medical and third-party carrier benefits to be paid directly to Symbios. I agree that I will be responsible for any remaining balance. I also authorize Symbios to release any information required to process a claim to my insurance carrier and/or employer. I acknowledge that I am financially responsible for services rendered and failure to pay any outstanding balances may result in collection procedures being taken. I also agree that if my account has a credit balance, the credit will be applied to any outstanding accounts of mine, or any family member that I am a guarantor for.

CONSENT FOR TREATMENT: I hereby authorize the providers to conduct examinations and to administer treatment as deemed medically necessary and advisable.

AFTER HOUR CALLS: I understand that any calls made after hours to the provider on call will be subject to a telemedicine visit and will be billed as such if deemed necessary by the provider.

NO SHOWS: I understand that if I fail to come to a scheduled appointment or do not cancel at least 24 hours prior, I may be charged a "No Show" fee. Ongoing occurrences may result in dismissal from the practice.

I have read, understand, and agree to be bound by the terms of the policies outlined and consent for treatment.

____ ______________________________

Signature of Patient or Parent Guardian if Minor   Date

____ ______________________________

Print Name of Patient or Parent Guardian if Minor   Date of Birth