NEWTON FAMILY MEDICINE
PATIENT REGISTRATION FORM

PATIENT INFO:

Last Name: _____First Name: _____MI:_____

Address:_____ City/ State_____

Zip Code:_____ Phone#_____

Date of Birth:_____ SSN#_____

Marital Status: S M D W P SEP Race:_____ Sex: M F

Emergency Contact Name:_____

Relation:_____Phone #_____

Preferred Pharmacy:_____

E-mail Address: _____

RESPONSIBLE PARTY (IF OTHER THAN PATIENT):

***This area to be completed if responsible party is someone other than the patient (ie: minor child, legal guardian, etc…)**

Last Name_____ First Name :_____MI:_____

Address:_____ City/ State_____

Zip Code:_____ Phone# _____

Date of Birth: _____ SSN#_____

Relationship to Patient:_____

PRIMARY INSURANCE INFO:

Insurance Co. Name:_____

Policy ID #:_____ Group # _____

Policy Holder Name:_____ DOB:_____

SSN:_____ Employer:_____

SECONDARY INSURANCE INFO:

Insurance Co. Name:_____

Policy ID #:_____ Group # _____

Policy Holder Name:_____ DOB:_____

SSN:_____ Employer:_____

Patient/ Guardian Signature:_____ Date:_____

Designated Party Release
Newton Family Medicine

You may give Newton Family Medicine written authorization to disclose your protected health information to anyone that you designate, such as a family member or personal representative. If you wish to authorize a person to receive your protected health information, please complete the form below. You may also use this form to give us consent to leave detailed information (results of labs, x-ray, prescription refills, etc.) on your home answering machine, voice mail at work, cell phone, e-mail, or another party that you designate.

Patient Name: _____Date of Birth:____/____/_____
Date:____/____/_____

At my request, I authorize Newton Family Medicine to disclose my protected health information to:
Name: _____Phone #:_____Relation:_____
Name: _____Phone #:_____Relation:_____
Name: _____Phone #:_____Relation:_____

At my request, I also authorize Newton Family Medicine to communicate my protected health information to me via the following methods:

- o Leave detailed message on my home answering machine (phone #: _____)
- o Leave detailed message on my voice mail at work (phone #: _____)
- o Leave detailed message on my cell phone voice mail (phone #: _____)
- o Fax detailed medical information (fax #: _____)
- o E-mail detailed medical information (e-mail: _____)

Authorized Signature:_____ Date:_____

I understand that I may cancel this authorization at any time by signing this notice below. However, if I cancel this authorization, I also understand that the cancellation will **not** affect any action Newton Family Medicine took in reliance on this authorization before receipt of written notice of cancellation.

Signature Authorizing Cancellation:_____

Date Authorization Cancelled: ____/____/_____

Form 10DPR Maintain a copy of the Designated Release Form with the administrative documents section of the
patients medical record.

Consent for Treatment, Assignment of Benefits, Release & Financial Policy

Thank you for choosing Newton Family Medicine (NFM) to meet your medical needs. We are dedicated to providing the best treatment available. Please read the below information carefully, initial each section and sign and date the bottom.

Patient Consent for Treatment

I voluntarily consent to any and all heath care treatment and diagnostic procedures provided by Newton Family Medicine and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other healthcare professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of treatments or examinations at Newton Family Medicine. Initials_____

Assignment of Benefits & Release of Information

I hereby authorize treatment of myself or the minor described above. I request payment from my insurance company be made to NFM. I understand that I am ultimately responsible for the balance of my account.

I authorize the release of all medical information necessary to process claims through my insurance carrier. I also authorize payment of medical benefits to NFM. If receiving a physical exam for employment, I authorize the release of the results of my exam to my employer.

I authorize NFM to obtain all of my medication/prescription history when using an electronic system to prescribe medications.

Initials_____

Financial Policy

Missed Appointments: A Missed Appointment fee may be charged if you do not show up for a scheduled appointment or cancel with less than 24 hours notice. This fee must be paid before a new appointment is scheduled. You may be discharged from NFM if you have more than 3 Missed Appointments. Initials_____

Account Balances: Patient account balances are due within 30 days of the receipt of the billing statement. Balances must be paid prior to services being rendered. If you are unable to pay your balance in full, we will have you speak with a representative to set up a payment plan. If you have an outstanding patient balance over 75 days old and have failed to make appropriate payment arrangements with our Business Office, your account may be turned over to an outside collection agency. If you have established a payment plan and fail to make agreed upon payments, your account may be turned over to a collection agency. Accounts assigned to Collections may be charged a $50 fee. Accounts turned over to an outside collection agency may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative care. During that 30-day period, our physicians will only be able to treat you on an emergency basis. Initials_____

Returned Checks: There is a $30.00 fee for returned checks. This fee plus your balance is due the next day after you are notified of the returned check. Initials_____

Insurance: NFM participates with many, but not all, insurance plans. It is your responsibility to contact your insurance company to verify that we participate with your plan and the physician you will be seeing is credentialed with them. A Valid Driver's License and Insurance Cards must be presented at each visit. If you do not have your up to date insurance card, we will be happy to reschedule your appointment or classify your appointment as self-pay. Self-Pay patients and patients who have not met their deductible are required to pay for services in full prior to leaving. It is your responsibility to inform us in a timely manner of any changes to your billing and insurance information. If an insurance company denies payment for incomplete or wrong information, it is your responsibility to make payment in full. Please be aware there is a time limit on how long we have to file insurance claims. If we miss the deadline because you did not provide us with the correct information, you will be responsible for payment in full. If your insurance company does not pay the practice within a reasonable period, we will transfer the balance to your responsibility. We request your assistance in following up with your insurance company to resolve any non-payment issues. It is your responsibility to pay the bill. Please be aware that some and perhaps all of the services you receive may be non-covered by Medicare or other Insurers. You are responsible for any and all portions of the bill not covered by your insurance plan. You must pay for these services in full at the time of visit. Co-pays must be paid on the date of service. Your Insurance Company may deny the claim if co-pays are not collected and you may be responsible for the entire charge. To prevent this, if you are unable to pay your co-pay, we will have to reschedule your appointment. Deductibles and co-insurance fees must be paid at check-out. Patients who are unable to pay for the services as required by their insurance will be required to speak with an account representative to set up a payment plan. All self-pay patients must pay for services rendered on the day of the appointment.

Initials_____

Signature of Patient or Responsible Party_____ Date:_____

NEWTON FAMILY MEDICINE

Welcome to our practice! We look forward to getting to know you. Please help us move things along by completing some background information regarding your medical history and current problems.

Last Name_____ First Name_____ DOB_____

Today's Date_____

Why did you come to the doctor today? _____

Please list the medical problems that ***you*** have been diagnosed with by a healthcare provider (high blood pressure, diabetes, heart problems, cancer, etc.):

	Medical Problem	When Diagnosed
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____

Have you ever had any surgeries? If yes, please list type of surgery and date:_____

_____

Did you ever choose not to have a surgery that was recommended? If yes, please list:_____

_____

Please list your ***current*** medications and dosages, if known. Please also list any OTC medicines and supplements you currently take.

_____	_____
_____	_____
_____	_____
_____	_____

Have you ever had an allergic reaction to any medication or food? If yes, please list the name of the food or medicine and the reaction it caused_____

_____

NEWTON FAMILY MEDICINE

(The following information is very important to your health and treatment)

Social History:

How many children do you have and what are their ages?_____

_____

If you work, what is your occupation?_____

Do you smoke cigarettes now or have you in the past?_____

No. of packs per day_____ Age when you started_____ Date you stopped_____

How much exercise do you get in a normal day or week?_____

Family History:

The medical problems that run in your family are very important for us to know about. Please explain in detail your family's medical problems. Be sure to think about problems like high blood pressure, diabetes, cancer, heart disease and alcoholism.

Family Medical Problem(s)

Mother_____
Father_____
Brother(s)_____
Sister(s)_____

Now think of grandparents, aunts, uncles, and cousins. Is there a family history of:

1. Heart attack at an early age (40's or 50's yrs)_____
2. Colon cancer/ polys_____
3. Breast or ovarian cancer_____
4. Other cancer_____

Vaccination History:

Approximate date of last tetanus shot if known_____

Please list known vaccinations and dates for Hep B, Pneumonia, Shingles, HPV_____

_____

Preventative Medicine:

Please provide the most recent dates and results (if known) for the following (if applicable):

Colonoscopy_____ Pap Smear_____
Mammogram_____ Bone Density Scan_____

Newton Family Medicine
1477 Tobias Gadson Blvd.
Charleston, SC 29407
(843) 766-7696

STIMULANT POLICY FOR NEW PATIENTS

Please pay close attention to our office policy. Dr. Newton and Dr. Kettinger **WILL NOT PRESCRIBE** any chronic narcotics, stimulants, or sedative medications. Please review, if you have any questions or concerns regarding this policy you may ask any of our clinical staff.

Narcotics/ Chronic Pain Mngmnt

- Vicodin
- Norco
- Oxycontin
- Hydrocodone
- Morphine
- Demerol
- Dilaudid
- Fentanyl
- Others

Sedatives

-Xanax
-Klonopin
-Ativan
-Valium
-Marijuana
-Diovan
-Soma

Stimulants

- Adderall
- Ritalin
- Concerta
- Vyvanse
- Others

Others

-Suboxone
-Zanaflex
-Methadone

Signature:_____

Date:_____

NEWTON FAMILY MEDICINE
1477 TOBIAS GADSON BLVD, CHARLESTON SC 29407
PHONE (843)766-7696 FAX (843)556-5882
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name(Please Print)_____**Date of Birth**_____
Address_____**Phone**(_____)_____
City_____**State**_____**Zip**_____
I authorize NFM to: (Check One) _____Release Information To: _____Obtain Information from:
Name_____
Address_____
City_____**State**_____**Zip**_____
Phone(_____)_____Fax(_____)_____

If to "self" (Check One) ___ Records on Paper Search & Retrieval $25 Pages 1-30 $0.65 Pages 30+ $0.55
___Records on CD (PDF files) $25
If the above box is not marked, the records will automatically be mailed/faxed.

Please check all that apply & specify dates if applicable:
__ Immunization Records
__ All Medical Records
__Office Visit Notes_____
__Radiology Reports_____
__Laboratory Reports_____
__Other:_____

Purpose of the Release:
__Referral
__ For Another Doctor
__Personal Use
__Transfer of Care
__Relocation
__Worker's Compensation
__Disability Determination
__Armed Forces Requirement
__Payment (Insurance Co., Etc.)
__Legal Matters

The records listed below have special protection bylaws. I authorize the release of information pertaining to:
__Diagnosis/Treatment of AIDS, HIV tests
__Diagnosis/Treatment of drug and/or alcohol abuse

__Treatment and/or consultation for mental health or psychological care.

Unless revoked/cancelled in writing, this authorization will expire one year from today's date or on _____.
I understand authorization of this form is voluntary. I do not need to sign this form to receive treatment. I understand this form carries with it the possibility of unauthorized disclosure by the organization receiving the information. I understand all employees, physicians or officers of Newton Family Medicine are released from legal liability for release of the above information to the extent indicated and authorized.
I understand the fees for copies of medical records are provided by *S.C. Law, SC ST SEC 44/115-80*.
Updated: 7/30/15

_____ _____
Signature of Patient/Legal Guardian/Representative **Date**

_____ _____
Print Name of Patient/Legal Guardian/Representative And Relationship to Patient **Witness Signature /Date**

NOTICE: EVERYTHING ON THIS FORM MUST BE FILLED OUT. IF ANYTHING IS MISSING OR INCORRECT, THE FORM WILL BE MAILED BACK TO THE PATIENT STATING WHAT NEEDS CORRECTED IN ORDER TO PROCESS. PLEASE ALLOW 7-10 BUSINESS DAYS TO PROCESS.

NEWTON FAMILY MEDICINE

(The following information is very important to your health and treatment)

Social History:

How many children do you have and what are their ages?_____

_____

If you work, what is your occupation?_____

Do you smoke cigarettes now or have you in the past?_____

No. of packs per day_____ Age when you started_____ Date you stopped_____

How much exercise do you get in a normal day or week?_____

Family History:

The medical problems that run in your family are very important for us to know about. Please explain in detail your family's medical problems. Be sure to think about problems like high blood pressure, diabetes, cancer, heart disease and alcoholism.

Family Medical Problem(s)

Mother_____
Father_____
Brother(s)_____
Sister(s)_____

Now think of grandparents, aunts, uncles, and cousins. Is there a family history of:

1. Heart attack at an early age (40's or 50's yrs)_____
2. Colon cancer/ polys_____
3. Breast or ovarian cancer_____
4. Other cancer_____

Vaccination History:

Approximate date of last tetanus shot if known_____

Please list known vaccinations and dates for Hep B, Pneumonia, Shingles, HPV_____

_____

Preventative Medicine:

Please provide the most recent dates and results (if known) for the following (if applicable):

Colonoscopy_____ Pap Smear_____
Mammogram_____ Bone Density Scan_____

Newton Family Medicine
1477 Tobias Gadson Blvd.
Charleston, SC 29407
(843) 766-7696

STIMULANT POLICY FOR NEW PATIENTS

Please pay close attention to our office policy. Dr. Newton and Dr. Kettinger **WILL NOT PRESCRIBE** any chronic narcotics, stimulants, or sedative medications. Please review, if you have any questions or concerns regarding this policy you may ask any of our clinical staff.

Narcotics/ Chronic Pain Mngmnt

- Vicodin
- Norco
- Oxycontin
- Hydrocodone
- Morphine
- Demerol
- Dilaudid
- Fentanyl
- Others

Sedatives

-Xanax
-Klonopin
-Ativan
-Valium
-Marijuana
-Diovan
-Soma

Stimulants

- Adderall
- Ritalin
- Concerta
- Vyvanse
- Others

Others

-Suboxone
-Zanaflex
-Methadone

Signature:_____

Date:_____