F. Marion Dwight, MD, PA • Bamberg Family Practice

Patient Information			
Name:	Date of Birth: _____/_____/_____		
Mailing Address:	City:	State:	Zip Code:
Social Security Number: _____-_____-_____	Gender at Birth: ☐ Male ☐ Female		
Home Phone:	Cell Phone:		
*Bamberg Family Practice may leave appointment information (lab/x-ray results, &/or other correspondence on my): Voice Mail (circle one): Yes / No			
Race:	Email:		

Parent/Guardian (Responsible Party) Information			
Name:	Date of Birth: _____/_____/_____		
Mailing Address:	City:	State:	Zip Code:
Home Phone:	Cell Phone:		
Race:	Email:		

Insurance Information
Please Provide a copy of all insurance cards to receptionist when checking in & with each visit
Name of Insurance:
Insurance number or member ID:
Policyholder's name:
Policyholder's Date of Birth: _____/_____/_____
Relationship to Patient (circle one): self spouse mother father other: _____

*We accept insurances including Medicaid, Medicare and Children's Health Insurance Program (CHIP). A discounted/ sliding scale fee schedule is available based on family size and income.

Also on back →

Emergency Contact Information

I, the Patient or the Patient's Responsible Party, hereby authorize Bamberg Family Practice to release <u>ANY/ALL</u> Protected Health information (both electronically &/or hard/paper copies) to the following person(s) named below unless otherwise specified:

Name:________________________ **Relationship:**________________ **Phone:**______________________

If you do **not** wish for <u>ANY/ALL</u> information to be released to the person listed above then please circle the following information you wish to be released.

Family/Billing/Financial - **ONLY** Medical - **ONLY**

Name:________________________ **Relationship:**________________ **Phone:**______________________

If you do **not** wish for <u>ANY/ALL</u> information to be released to the person listed above then please circle the following information you wish to be released.

Family/Billing/Financial - **ONLY** Medical - **ONLY**

Name:________________________ **Relationship:**________________ **Phone:**______________________

If you do **not** wish for <u>ANY/ALL</u> information to be released to the person listed above then please circle the following information you wish to be released.

Family/Billing/Financial - **ONLY** Medical - **ONLY**

Rights of the Patient: I understand that I have the right to revoke this authorization at any time & that I have the right to inspect the Protected Health information to be disclosed as described in this document by sending written documentation to F. Marion Dwight, MD, PA (Bamberg Family Practice). I understand that a revocation is not effective in cases where this information had already been disclosed but will be in effect going forward. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient & may be no longer protected by federal &/or state law. I understand that I have the right to refuse to sign the authorization & that my treatment will not be conditional upon signing. This authorization shall be in effect until revoked by me, the patient &/or my responsible party.

Name (Printed):____________________________________ **Signature:**______________________________

Date:______________________

Authorization for Release of Medical Information for Payment & Treatment: I authorize F. Marion Dwight, MD, PA (Bamberg Family Practice) to release any information (including medical information) for insurance or third-party payer claim(s) submissions &/or payment for services. I also authorize those benefits from the insurance company of any third-party payer be paid directly to F. Marion Dwight, MD, PA (Bamberg Family Practice). I guarantee payment in full to F. Marion Dwight, MD, PA (Bamberg Family Practice) for the amount due upon completion of services. I also acknowledge that I am responsible for any/all services &/or treatments not covered by my insurance & agree to pay my balance in a timely manner. I authorize the release of my personal medical information for the purpose of providing, coordinating, & managing my health care, this includes (but is not limited to) the coordination of management of my health care with a third party such as another physician or health care agency. I do hereby voluntarily consent to such diagnostic procedures, hospital care, medical, & surgical treatment by F. Maron Dwight, MD, PA (Bamberg Family Practice) physician(s), physician assistants, nurse practitioner(s), nurses, medical assistants, or physician's designees as is necessary in his/her judgement. I acknowledge that no guarantees have been made to me as the result of treatments or examinations in the facility.

Name (Printed):____________________________________ **Signature:**______________________________

Date:______________________

F. Marion Dwight, MD, PA • Bamberg Family Practice

Patient Name: _____

Males:

Date of last colonoscopy _____ Date of last PSA _____

Females:

Date of last period _____ Date of last Pap _____

Date of last Mammogram _____ Date of last colonoscopy _____

List All Surgical procedures you have had in your life time & the year you had them:

- _____/_____
- _____/_____
- _____/_____
- _____/_____

Specialist (Does the patient see any specialty practitioners, i.e., Cardiologist, Nephrologist, Gastroenterologist, Endocrinologist, Rheumatologist, Chiropractors?):

Type of Specialist	Name of the Practice	Phone Number & City/Town

F. Marion Dwight, MD, PA
Bamberg Family Practice
2113 Main Hwy., PO Box 120
Bamberg, SC 29003
803-245-5168 FAX: 803-245-6275

I authorize F. Marion Dwight, MD, PA to request my medication list from all participating pharmacies.

Patient Name _____ **Date of Birth** _____

Patient's Signature or Authorized Signature _____ **Date Signed** _____

LOCAL PHARMACIES

Place a check beside the pharmacies you use.
If not listed write in the name and city.

√	
	CVS (Denmark)
	CVS (Orangeburg-Calhoun)
	CVS (Orangeburg-Magnolia)
	CVS (Barnwell)
	Daniels (Barnwell)
	Daniels (Norway)
	Daniels (Denmark)
	Ehrhardt Pharmacy
	Giant Pharmacy (Neeses)
	Grove Park
	Hiers Drug Store
	Wal-Greens (Bamberg)
	Wal-Greens (Calhoun)
	Wal-Greens (St Matthews Rd)
	WalMart (Barnwell)
	WalMart (Orangeburg)
	R & J Pharmacy (Norway)
	Express Scripts
	Optum Rx
	WalMart Neighborhood Pharmacy (Orangeburg)

HIPAA Notice of Privacy Practices

F. MARION DWIGHT, MD, PA • BAMBERG FAMILY PRACTICE
2113 MAIN HWY. • PO BOX 120
BAMBERG, SC 29003 803-245-5168

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED 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 (PHI) to carry out treatment, payment or health care operations (TPO) 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, clinical photography for diagnosis and treatment, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected health information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related service. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, naming of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations- You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request, if physician believes it is in your best interest to permit use and disclose your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

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 contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name _____ **Signature** _____ **Date** _____

Bamberg
FAMILY PRACTICE

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Today's Date:_____

I. AUTHORIZATION

I, _____, hereby voluntarily authorize the disclosure of information from my health record.
(Name of Patient) Patient DOB: _____

II. THE INFORMATION IS TO BE DISCLOSED BY:	III. AND IS TO BE PROVIDED TO:
NAME OF FACILITY	F. Marion Dwight, MD, PA
ADDRESS	2113 Main Highway
CITY/STATE	Bamberg, SC 29003

IV. THE PURPOSE OF THE AUTHORIZATION

☐ At my request ☐ Other: _____

V. THE INFORMATION TO BE DISCLOSED

☐ All of my health information
☐ My health information relating to the following treatment or conditions:

_____

☐ My health information covering the period of healthcare from:
_____ (start date to _____ (end date)
☐ Other: _____

VI. THIS AUTHORIZATION ENDS:

☐ On: _____ (date)
☐ When I am no longer a patient of F. Marion Dwight, MD, PA
☐ When the following event occurs: _____

I authorize the release of the records as indicated above and understand that the release may include sensitive information (mental and behavioral health, HIV/AIDS, communicable/infectious diseases, substance use disorder(s) and sexual assault.)

I understand that I have a right to cancel/revoke this authorization at any time. I understand that to do so I must put it in writing and present the written cancellation/revocation to the medical records department. I understand that the cancellation/revocation will not apply to information that has already been released. I understand that authorizing the disclosure of protected health information is voluntary. I have the right to refuse to sign this authorization. I do not need to sign this form to receive treatment. I understand that I may review and/or copy the information to be disclosed, as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the possibility of unauthorized disclosure by the person/organization receiving the information. I understand there may be fees for copies of medical records/images and postage fees may be charged as provided by S.C. Law. I understand that I will receive a copy of this authorization after I have signed it.

_____ _____
Signature of Patient or Legal Guardian/Representative Date

_____ _____
Relationship to Patient, if not signed by Patient Date of Birth of Patient