

## LCR PATIENT INFORMATION

Last Name		First Name			Middle Init
Street Address				Apt/Lot #	
City		State	Zip	DOB	
Social Security #        -        -			Circle One:   Mr.   Mrs.   Ms.   Miss   Dr.		
Cell Phone (        )        -			Phone Number (        )        -		
Email Address			Employment   Full-time   Part-time   Retired   Disabled		
Race	Sex    M        F	Marital Status   S   M   W   D		Student?   Yes   No   Full-time   Part-time	

Referring Physician	Phone Number
Primary Care Physician	Phone Number
Spouse	Phone Number
Emergency Contact	Phone Number

<b>Primary Insurance</b>		
Policy Holder Name	DOB	SSN
Policy Number	Group #	Group Name
<b>Secondary Insurance</b>		
Policy Holder Name	DOB	SSN
Policy Number	Group #	Group Name

Consent for Treatment, Payment, and Acknowledgement of Receipt of Notice of Privacy Practices: I request that payment under the medical insurance program be made payable to Lowcountry Rheumatology for services rendered. I understand that I am financially responsible for all charges incurred at Lowcontry Rheumatology. I authorize disclosure of my personal health information to carry out treatment, payment, or health care procedures. I have received the privacy policy and Notice of Information Practices that provides a more complete description of information uses and disclosures. I agree to pay any and all charges that exceed or not paid/covered by my insurance. In the event my account is turned over to a collection agency, I will be billed the additional collection fees.

Patient / Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Signature