Patient Information

Today's Date:_____

Reason for Visit:_____

Have you been a patient of Tricia Amelung before? _____

Who Referred you to Lowcountry Family Care?_____

Patient Demographics

First Name | Last Name | M

Address | Apt#

City | State | Zip

Home Phone | Mobile Phone

Social Security # | Gender | DOB

Language | Marital Status | Email Address

Race | Ethnicity

Emergency Contact Information

Responsible Party/ Guarantor | Phone# | Relationship to Patient

Contact #1 | Phone# | Relationship to Patient

Contact #2 | Phone# | Relationship to Patient

Pharmacy Information

Preferred Pharmacy _____ Location:_____

Secondary Pharmacy _____ Location:_____

Patient Medical History

Patient Name: _____ DOB: _____

Allergies

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Other: _____

_____

Family History

Mother: __Hypertension __Diabetes __Cancer __Other (please specify)_____ __N/A

Father: __Hypertension __Diabetes __Cancer __Other (please specify)_____ __N/A

Brother: __Hypertension __Diabetes __Cancer __Other (please specify)_____ __N/A

Sister: __Hypertension __Diabetes __Cancer __Other (please specify)_____ __N/A

Medications With Dosages

Medication: _____ Dosage: _____	Medication: _____ Dosage: _____
Medication: _____ Dosage: _____	Medication: _____ Dosage: _____
Medication: _____ Dosage: _____	Medication: _____ Dosage: _____
Medication: _____ Dosage: _____	Medication: _____ Dosage: _____
Medication: _____ Dosage: _____	Medication: _____ Dosage: _____
Medication: _____ Dosage: _____	Medication: _____ Dosage: _____
Medication: _____ Dosage: _____	Medication: _____ Dosage: _____

Past Medical History:

Head Aches	☐ Yes	☐ No	Date: _____
Stroke	☐ Yes	☐ No	_____
Seizures	☐ Yes	☐ No	_____
Pneumonia	☐ Yes	☐ No	_____
Diabetes (Type 1 or Type 2)	☐ Yes	☐ No	_____
Thyroid Disease (Low or High)	☐ Yes	☐ No	_____
Glaucoma	☐ Yes	☐ No	_____
Macular Degeneration	☐ Yes	☐ No	_____
Hearing Loss	☐ Yes	☐ No	_____
High Blood Pressure	☐ Yes	☐ No	_____
Blood Clots	☐ Yes	☐ No	_____
☐ Pulm Emboli (lung clots)	☐ Yes	☐ No	_____
☐ DVT (leg clots)	☐ Yes	☐ No	_____
Heart Burn, Reflux	☐ Yes	☐ No	_____
Stomach Ulcers	☐ Yes	☐ No	_____
Heart Disease	☐ Yes	☐ No	_____
☐ Coronary Disease	☐ Yes	☐ No	_____
☐ MI/heart attacks	☐ Yes	☐ No	_____
☐ Congestive Heart Failure	☐ Yes	☐ No	_____
☐ Atrial Fibrillation	☐ Yes	☐ No	_____
☐ Angina	☐ Yes	☐ No	_____
☐ Valve Disorder	☐ Yes	☐ No	_____
High Cholesterol	☐ Yes	☐ No	_____
Gastrointestinal Bleeding	☐ Yes	☐ No	_____
Hepatitis (A, B, C)	☐ Yes	☐ No	_____
HIV / AIDS	☐ Yes	☐ No	_____
Chronic Wounds	☐ Yes	☐ No	_____
Cancer (type)	☐ Yes	☐ No	_____
Urinary Tract Infections	☐ Yes	☐ No	_____
Incontinence	☐ Yes	☐ No	_____
Kidney Stones	☐ Yes	☐ No	_____
COPD (Emphysema, Bronchitis)	☐ Yes	☐ No	_____
Asthma	☐ Yes	☐ No	_____
Depression	☐ Yes	☐ No	_____
Bipolar Disorder	☐ Yes	☐ No	_____
Anxiety	☐ Yes	☐ No	_____
Fibromyalgia	☐ Yes	☐ No	_____
Chronic Fatigue Syndrome	☐ Yes	☐ No	_____
Arthritis	☐ Yes	☐ No	_____
Gout	☐ Yes	☐ No	_____
Osteoporosis	☐ Yes	☐ No	_____
Prostate Disease	☐ Yes	☐ No	_____
Breast Disease	☐ Yes	☐ No	_____
Erectile Dysfunction	☐ Yes	☐ No	_____

Other _____

Habits:

Alcohol: ☐ None ☐ Yes: How many drinks/day _____ frequency/week _____ What kind_____

Tobacco: ☐ None ☐ Yes: Chew or smoke?_____ How many/day _____ since_____

Caffeine: ☐ None ☐ Yes: What kind_____ How many/day _____

Other Recreational Drugs: ☐ None ☐ Yes: What kind_____ How many/day _____

Do you drive? ☐ Yes ☐ No Do you always wear a seatbelt? ☐ Yes ☐ No

Do you exercise? ☐ Yes ☐ No If yes, how much?_____

Social History:

Work: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled

Current Occupation _____ Former Occupation _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Domestic Partner

Sexual preference: ☐ Men ☐ Women ☐ Both

Children (age):_____

Hobbies:_____

Sports:_____

Pets:_____

Other:_____

Past Surgical History (indicate date if known)

- ☐ None
- ☐ Cataracts_____
- ☐ LASIK_____
- ☐ Tonsillectomy_____
- ☐ Thyroidectomy_____
- ☐ Adenoidectomy_____
- ☐ Coronary Bypass_____
- ☐ Cardiac Stents_____
- ☐ Pacemaker_____
- ☐ Heart Valve_____
- ☐ Gall Bladder_____
- ☐ Appendectomy_____
- ☐ Bowel/Stomach Resection_____
- ☐ Hemorrhoidectomy_____
- ☐ Bariatric surgery_____
- ☐ Hysterectomy_____
- ☐ Endoscopy_____
- ☐ Colonoscopy_____
- ☐ Hernia_____
- ☐ Spinal Surgery_____
- ☐ Tubal Ligation_____
- ☐ Bladder surgery_____
- ☐ Prostate surgery/resection_____
- ☐ C-Section_____
- ☐ Orthopedic/joints_____
- ☐ Other_____

_____

_____

_____

_____

Patient Consent to Treatment

Responsible Party Information

Name of Responsible Party | DOB | Phone Number #

Address | City | State | Zip

Medical Insurance Information

Primary Insurance Company | Policy Number

Policy Holder's Name | Relationship to Patient | Policy Holder's Date of Birth

Secondary Insurance Company | Policy Number

Policy Holder's Name | Relationship to Patient | Policy Holder's Date of Birth

Patient Consent for Treatment

1. I voluntarily consent to any and all health care treatment and diagnostic procedures provided by Lowcountry Family Care - Tricia Amelung FNP-BC 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 the treatment of examinations at Lowcountry Family Care.
2. I consent to the use and disclosure of my/the patient's protected health information for the purposes of obtaining payment for services rendered to me/ the patient, for treatment and healthcare operations consistent with the Lowcountry Family Care Notice of Privacy Practices.
3. I authorize payment of medical benefits to Lowcountry Family Care - Tricia Amelung FNP-BC for services rendered. I further understand that any balance remaining after insurance approves or denies payment is my responsibility to pay.
4. I give permission to obtain all my medication-prescription history when using an electronic system to process prescriptions for my medical treatment.

I have received a copy of the Notice of Privacy Practice, Financial Policy Notice, and Release of Information.

Patient Signature | Date

PATIENT CONSENT TO SHARE PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ DOB: _____

Please list the person(s) to whom we may disclose the following information:

Your past, present, and future physical or mental health.

The provision of your health care.

Your past, present, and future payment for health care.

The person(s) may be a spouse, family member, close friend, or caregiver who can act as a liaison or trusted person to share your personal health information in your absence.

Full Name	Phone Number	Relationship to Patient
Full Name	Phone Number	Relationship to Patient
Full Name	Phone Number	Relationship to Patient

I acknowledge that this consent will remain in place until my written notification requesting a change has been received and processed.

Signature:_____ Date:_____

Patient/Guardian Signature:_____ Date: _____

Financial Policy and Disclosure

Name:_____DOB:_____

The Financial Policy and Disclosure is to help us provide the most efficient and reasonable health care services. Therefore, it is necessary for us to have a Financial Policy and Disclosure stating our requirements for payment for services provided to patients.

Patients are responsible for the payment of all services provided by Lowcountry Family Care.

Self-Pay Policy

- If you are a self-pay patient, you will be required to pay at the time of the visit. Additionally, any outstanding balance on your account will be collected at the conclusion of your visit.
- New patients will be required to pay $165.00 for their first office visit.**
- Established patients will be required to pay $125.00 per office visit.**

***This does NOT include labs or additional procedures performed.**

Insurance Policy

- If you are an insurance patient, it is our policy to file for insurance as a courtesy to you, if we have accurate and complete information.
- If a service is provided that is not covered by your insurance company, you will be the responsible party at the time of service.
- Deductibles, co-payments, and coinsurance will be due at the time of the visit.
- In some cases, we may need your help in contacting your insurance company for the payment of your services.

Cash Services Policy

- If you would like to participate in Biote Hormone Replacement Therapy, you are expected to pay for the procedure at the time of the visit. **This procedure is not covered by insurance.**
- If you would like to purchase Biote supplements through Lowcountry Family Care, payment is expected at the time of purchase.
- We do have a 3% charge on all credit or debit card transactions. Cash is preferred.
- A service fee of $35 will be charged for any bounced checks.

Cancellation Policy

- Please notify us by phone at least 24 hours in advance of your scheduled appointment if you need to cancel for any reason (or by 5:00 pm the Thursday prior to a Monday appointment). If you miss a scheduled appointment or cancel within 24 hours of the scheduled appointment, you will be charged a no-show fee of $25.00 (Insurance companies do NOT cover this fee).
- Medicaid patients who miss more than three consecutive appointments will be discharged from future services.

To help with this policy, we ask that you assist us by

1. Providing us with current and updated information on yourself and your insurance company.
2. Presenting us updated photo identification care and insurance cards when changes are made.
3. Make the appropriate payment at the time of service, whether it is a deductible, copay, coinsurance, or full amount if you are a Self-Pay patient.

In order to provide the best medical care, we ask that you do not discuss your account balance or financial aspects with our physician or medical staff. Please discuss and account information with the checkout associate at the front desk.

_____

Responsible Party's Signature Date