

**Mt Pleasant Internal Medicine**  
**897 von Kolnitz Rd. Ste 101**  
**Mt. Pleasant, S. C. 29464**  
**Office: 843 881 1671 Fax: 843 881 1433**

**REGISTRATION FORM**

Date:

Patient name:

DOB:

Address:

Sex:

City, State and Zip:

Social Security:

Home Phone:

Work:

Cell:

Email:

Spouse name:

Emergency contact: (other than spouse):

Emergency number:

Patient's employer:

Phone:

Employer's address:

City, State and Zip:

Primary Insurance:

Policy holder: (other than self):

Address:

City, State and Zip:

Secondary Insurance: (secondary insurance is filed **ONLY** if the patient has Medicare)

Address:

City, state and Zip

**YOU WILL NEED TO BRING YOUR INSURANCE CARD, A FORM OF PICTURE ID AND ANY COPAYMENT..**

Patient name:

DOB:

Date:

**OFFICE POLICY**

Cancellation policy: Patients failing to cancel an appointment without 24 hours notice are subject to a \$25.00 missed appointment fee.

Check policy: Any returned checks will be credited back to your account and a \$25.00 returned check charge will be added. You will have 1 week to return to the office with cash or money order.

Self pays: Patients without health insurance will receive a discounted at time of check out.

Check out policy: All co-pays and past due balances will be collected at time of check out.

Prescription policy: Any prescriptions requiring prior authorizations will have to have a form faxed to the office from the insurance company upon request from the patient.

**\*\*\*\*\*RELEASE OF INFORMATION AND ASSIGNMENTS OF BENEFITS DECLARATION:\*\*\*\*\***

Patient requesting us to file claims on their behalf to Medicare or their insurance company authorize release of any medial information necessary to process their insurance claims and also assign to Mt. Pleasant Internal Medicine, PA all payments from Medicare or any insurance company for services rendered.

Not all insurance companies pay for Physical Exams, Vaccines, or Procedures performed in our office. Please be aware of your insurance policies; payment for these services are your responsibility at the time they are rendered, unless agreement is made in advance with our billing coordinator.

May we leave messages with lab results on your answering machine (cell/home) YES/NO Initial:

May we send lab results to you via your email address listed above? YES/NO Initial:

Acknowledgments: I acknowledge and agree to the terms and conditions of the Policies described and all of the above information is correct.

Date:

Signature: