

**Coastal Therapeutics, P.A.**  
**Patient Questionnaire**

**Patient Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City, State, Zip** \_\_\_\_\_

**Job Title:** \_\_\_\_\_ **Employer:** \_\_\_\_\_

**Employer Address:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**D.O.B.:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **SSN:** \_\_\_\_ - \_\_\_\_ - \_\_\_\_ **Sex:** M F

**Marital Status:** S M O **Driver's License # & State:** \_\_\_\_\_

**Insurance Company:** Please give us a copy of your insurance card.  
Please list all information necessary to file your claims and provide a signed copy of your subscriber information form if necessary for filing.

**Group No:** \_\_\_\_\_ **Policy No.** \_\_\_\_\_ **Effective:** \_\_\_\_\_

**Policy Holder Name:** \_\_\_\_\_ **D.O.B.** \_\_\_\_\_

**Relation to patient:** \_\_\_\_\_ **Policy Holder S.S.N.:** \_\_\_\_\_

**Policy Holder Address:** \_\_\_\_\_ **Job Title:** \_\_\_\_\_

**Circle One: If This is** Worker's Comp Auto Accident Or Medicare

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**In Case of Emergency: Contact:** \_\_\_\_\_ **Phone No:** \_\_\_\_\_

**Give a brief description of HOW/WHEN/WHERE injury occurred:**  
\_\_\_\_\_  
\_\_\_\_\_

**If Attorney Case Please complete: Attorney Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**PLEASE READ AND COMPLETE BACK OF THIS FORM.**

Release of Medical Information: I hereby authorize the release of medical information which is requested by my physician or insurance carrier.

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

Authorization for Direct Insurance Payment: I hereby authorize direct payment of benefits from the insurance (s) listed herein to Coastal Therapeutics for the fees incurred by me at Coastal Therapeutics, P.A.

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

Collection Action: Our patients are honest, hard working people. If for any reason you find it difficult to pay your fees we will work out a payment plan for you. Communication is important. Please keep us informed of your ability to pay your fees. If we cannot avoid collection action will be held responsible for all fees related to collection of your account. We hope this will never be necessary.

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

**IF YOU CANNOT MAKE IT TO YOUR SCHEDULED APPOINTMENT PLEASE CALL AT LEAST 24 HOURS IN ADVANCE TO CANCEL AND RESCHEDULE. FAILURE TO DO SO WILL RESULT IN A \$30.00 CHARGE.**

**IF YOU ARE GOING TO BE MORE THAN 5 MINUTES LATE PLEASE CALL AND LEFT US KNOW. YOUR COURTESY IS APPRECIATED.**

**Coastal Therapeutics PA**  
**NOTICE OF PATIENT INFORMATION PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

**Coastal Therapeutics PA's LEGAL DUTY**

Coastal Therapeutics PA is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

**USES AND DISCLOSURES OF HEALTH INFORMATION**

Coastal Therapeutics uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, Coastal Therapeutics PA may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Coastal Therapeutics may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Coastal Therapeutics PA's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Coastal Therapeutics PA may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

**PATIENT'S INDIVIDUAL RIGHTS**

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Coastal Therapeutics PA will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

**CONCERNS AND COMPLAINTS**

If you are concerned that Coastal Therapeutics PA may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Coastal Therapeutics PA's health information practices or if you have a complaint, please contact the following person:

**Coastal Therapeutics PA**

*Nancy Rourk*

570 Long Point Road Suite 270 Mt Pleasant SC 29464 Telephone: 884-4783

Fax: 884-4783

**Coastal Therapeutics PA**

PATIENT INFORMATION CONSENT FORM

I have read and fully understand Coastal Therapeutics PA's Notice of Information Practices. I understand that Coastal Therapeutics may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Coastal Therapeutics will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Coastal Therapeutics PA's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

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Patient Name

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Signature

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Date