PREMIER MEDICAL
PRIMARY • URGENT • FAMILY

New Patient Information

Name: _____ **SSN:** _____ - ____ - _____
First Middle Last

DOB: ____ / ____ / _____ **Gender:** M F
MM DD YYYY (Circle)

Address: _____ _____ _____ _____
Street Address / Apt / Suite City State Zip Code

Phone: (_____) _____ - _____ **Email:** _____

Responsible Party / Guarantor, if different than Patient

Name: _____
First Middle Last

SSN: _____ - ____ - _____ **DOB:** ____ / ____ / _____
MM DD YYYY

Address: _____ _____ _____ _____
Street Address / Apt / Suite City State Zip Code

Phone: (_____) _____ - _____ **Email:** _____

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Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Premier Medical of SC LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

(The Notice of Privacy Practices provided by Premier Medical of SC LLC describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Premier Medical of SC LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Premier Medical of SC LLC at 354 Folly Road, Charleston, SC 29412.

With this consent, Premier Medical of SC LLC may:

- Call my home, cell phone or other alternative phone number and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as follow-up reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.
- Mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as follow-up reminders and patient statements.
- Email to my home or other alternative location any items that assist the practice in carrying out TPO, such as follow-up reminders and patient statements.
- Discuss my medical condition with the following individuals:

  _____

  _____

  _____

I have the right to request that Premier Medical of SC LLC restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Premier Medical of SC LLC to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Premier Medical of SC LLC may decline to provide treatment to me.

_____ _____
Signature of Patient (or Legal Guardian) Date

_____
Print Patient's Name

_____
Print Name of Legal Guardian, if applicable

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Name: _____ DOB: _____

** PLEASE WEAR MASK **

PREMIER MEDICAL COVID-19 QUESTIONNAIRE:

Please pick the situation that best describes your reason for testing:

____ I currently have symptoms of COVID-19 and wish to be tested

____ I think I have been exposed to COVID-19, but I do not have any symptoms

Date of exposure: _____

Relationship/circumstances of exposure: _____

____ I have not knowingly been exposed, but I need screening for work or travel

____ I am interested in COVID-19 Antibody Testing, to see if I have been exposed in the past

I have the following underlying medical conditions:

_____

I take the following medications regularly:

_____