PATIENT DEMOGRAPHIC VERIFICATION FORM

		UPDATE INFORMATION BELOW
Responsible Party		
Name		
Address		
Phone Number		
Patient Information		
Name		
Mailing Address		
Alternate/Local Address		
Phone Number		
Cell Phone Number		
Email Address		
Date of Birth		
Patient Sex		
Marital Status		
Age		
Social Security Number		
Emergency Name		
Emergency Phone		
Preferred Language		

Race: ❑ American Indian or Alaskan Native ❑ Asian ❑ Native Hawaiian or other Pacific Islander ❑ Black or African American ❑ White ❑ Other Race ❑ Unreported/Refused to Report

Ethnicity (Cultural Background) ❑ Hispanic or Latino ❑ Non-Hispanic or Latino ❑ Refused to Report

Have you received medical care from any other healthcare provider since your last visit in our office? ❑ Yes ❑ No

Do you have an Advanced Directive? ❑ Yes ❑ No | ❑Living Will ❑ Organ Donor ❑DNR ❑ Power of Attorney ❑ Other

Employer Information		
Name of Employer		
Employer Address		
Employer Phone Number		
Health Insurance		
Primary Insurance Name	--	
Primary Claim Address		
Primary Phone Number		
Primary Policyholder		
Primary Subscriber Number	--	
Primary Group Number		
Secondary Insurance Name	--	
Secondary Subscriber Number	--	
Secondary Group Number		
Pharmacy Information		
Pharmacy Name		
Pharmacy Address		
Pharmacy Phone Number		

I certify the above demographic and insurance information listed above to be correct. I hereby authorize any insurance benefits to be paid directly to the physician providing services and recognize my responsibility to pay for all non-covered services. I also authorize the physician to release any information necessary to process an insurance claim

X	**Date**

Tri-County
Surgical Associates
TRIDENT HEALTH

9239 Medical Plaza Drive, Charleston, SC 29406
Phone: (843) 797-5151 Fax: (843) 572-6939

Thomas C. Litton, M.D., FACS Jeffrey M. Lafond, M.D., FACS David W. Ford, M.D., FACS
Piper J. McCord, PA-C Andrea H. Bessinger, PA-C

Welcome to our Practice

At Tri-County Surgical Associates we value you as a patient and hope to make your visit in our office as pleasant as possible. Please take a few moments to read the following. We are happy to answer any questions you may have.

CO-PAYS and PAST BALANCES: Copayments are collected prior to each office visit. Every attempt is made to collect your past due balance as you check in or out of our office. We will make every effort to work with you regarding any past due balances.

INSURANCE POLICIES & REFERRALS: We participate with most insurance plans; however it is the patients' responsibility to contact their insurance company to make certain that our practice/physician is listed as participating with your plan. If your plan requires a referral from your primary care physician to see a specialist, you are required to obtain this referral prior to your scheduled appointment. Your appointment may have to be rescheduled if this required referral has not been received by our office. Medicaid patients that have exhausted their allowed number of visits will be financially responsible for the visit or may be rescheduled when additional days are granted.

WORKER'S COMPENSATION: Verifiable contact information and authorization must be provided to our office when scheduling an appointment for a work-related injury.

FORMS-INSURANCE, LONG & SHORT TERM DISABILITY: There is a $20.00 fee for completion of insurance forms. We do not accept any faxed forms or those dropped in our mail slot. All forms should be submitted to our receptionist along with the fee. If you wish to have your form faxed after completion, please provide a valid fax number.

APPOINTMENT DELAYS: Due to the nature of our practice, your physician may be delayed because of unforeseen events or emergencies. We will make every effort to keep you informed if your appointment is going to be delayed and to reschedule your appointment to the next available time/day. Please notify our receptionist if you are not seen within 30 minutes of your appointment time.

PRESCRIPTION REFILLS: Please try to anticipate your needs during your visit. When requesting a refill of your medication please allow at least 24 hours for refills to be completed. We do not refill prescriptions after 2:30pm on Fridays or on the weekends.

Please bring the enclosed paperwork with you to your appointment, do not mail.

Thank you for allowing our practice to participate in your care.

Know the early signs of a stroke - Face drooping, Arm weakness, Speech difficulty, Time to call 911

Tri-County Surgical Associates

General Consent for Care and Treatment

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	**Date**
Printed Name of Patient or Personal Representative	**Relationship to Patient**
Printed Name of Witness	Employee Job Title
Signature of Witness	**Date**