Compass Family Medicine
2605 KINARD ST. STE 208
NEWBERRY, SC 29108
P: 803-276-4860
F: 803-276-2812

NEW PATIENT PACKET

Welcome to our office!

When you arrive for your first appointment, please bring the following with you:

1. All of your health insurance cards.
2. Photo identification
3. All medications you are currently taking, including vitamins and over the counter medications
4. A form of payment for any applicable co-pays, deductibles, and/or services not covered by insurance.

If you have any questions or need to reschedule an appointment, please call our office. We do require 24-hour notice if you are unable to keep a scheduled appointment. Our office does have a 3-strike policy. If you schedule an appointment and do not show up without notifying the staff that you will not be able to make it, it will be considered a strike. After 3 strikes we will have to dismiss you as a patient for noncompliance. Thank you for choosing Compass Family Medicine, PA to help with your health care needs.

Sincerely,
The Staff and Providers of Compass Family Medicine

Today's Date:_____ **Account Number:**_____
(for Staff use only)

PATIENT INFORMATION

Name:_____
(First) (Middle) (Last)

Home Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Race:_____ Age: _____ SSN:_____ DOB:_____

Employer:_____

Employer Address:_____

City:_____ State:_____ Zip:_____ Phone:_____

Surgical History: Please write the surgery that you have had, as well as the year the surgery was done.

Surgery	Year

MEDICATIONS

Current Medications: Please include over the counter medications, vitamins, and food supplements.

DRUG NAME	STRENGTH	HOW OFTEN?

Are you **ALLERGIC** to any **MEDICATIONS**? Yes No

If yes, which medications and what is the reactions? _____

_____

Please state your preferred pharmacy and its location: _____

_____

Our office will file insurance for all reimbursable services, to both your primary and secondary insurances carriers. Please remember that you are responsible for all deductibles, co-pays, and non-covered service amounts. It is your responsibility to inform our office staff of any changes to your current insurance or if you have a new insurance.

I authorize the release of any medical information necessary to process my claim. **Initial:**_____

I authorize payment of medical and surgical benefits to Compass Family Medicine (Corey D. Hunt, M.D.). **Initial:**_____

I agree that I will pay the balances that my insurance company does not pay. **Initial:**_____

Signature of Patient/Legal Guardian:_____

Date:_____

MEDICAL HISTORY

Please review the list below and check any problems you have had now or in the past:

Abnormal Pap Smear		Eczema		Osteopenia	
Acne		Emphysema		Osteoporosis	
ADD/ADHD		Frequent UTI's		Positive TB Skin Test	
Alcohol Abuse		Freq. Sinus Infection		Prostate Problems	
Anemia		Gallstones		Psoriasis	
Anxiety		Glaucoma		Reflux (heartburn)	
Asthma		Gout		Rheumatoid Arthritis	
Bipolar		Heart Attack		Rosacea	
Blood Clot		Heart Conditions (specify)		Seasonal Allergies	
Blood Transfusion		Hepatitis (specify A,B,C)		Seizures	
Cancer (specify)		High Blood Pressure		STD (specify)	
Chronic Bronchitis		High Cholesterol		Stomach Ulcers	
Crohn's Disease		Kidney Disease		IBS	
Colon Polyps		Kidney Infections		Stroke	
Depression		Kidney Stones		Tuberculosis	
Diabetes		Lupus		Thyroid Disease	
Diverticulitis		Melanoma or Skin Cancer		Ulcerative Colitis	
Drug Abuse		Migraines		Warts	
Eating Disorder		Osteoarthritis			

Other medical problems not listed:_____

_____

EMERGENCY CONTACT

Name:_____ Relationship:_____

Phone:_____

Signature of Patient/Legal Guardian:_____

Date:_____

By signing the above line, you are agreeing that the person listed above is allowed to receive information in regards to appointment dates and balances due by the patient.

If you are 18 or older and do not have a medical necessity that requires someone to come in the room with you, such as parent/guardian/medical power of attorney, you have to speak with Dr. Hunt alone at your visit per HIPAA regulations.

PAYMENT

Complete this section only if someone other than the patient is financially responsible

Responsible Party:_____ Relationship:_____

Home Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

DOB:_____ Age:_____ SSN:_____

Employer:_____ Phone:_____

Primary Insurance

Name of Insurance Company:_____

Insured's Name:_____

Policy ID Number:_____ Group:_____

Secondary Insurance

Name of Insurance Company:_____

Insured's Name:_____

Policy ID Number:_____ Group:_____

For Women:

Last menstrual period: Are you menopausal? Yes No

Last pap smear: Age at onset of menopause:

Last mammogram: # of pregnancies:

Last bone density (DEXA): # of children:

Family History: Have any of your family members had any of the following problems? Please check and list the family member:

Check	Illness	Family Member	Check	Illness	Family Member
	Heart Disease/ Attack			Migraines	
	High Blood Pressure			Prostate Cancer	
	Depression			Anxiety	
	Other Mental Illness			Asthma	
	Osteoporosis			Diabetes	
	Colon Cancer			Thyroid Disease	
	Ovarian Cancer			Alcoholism	
	Stroke			Breast Cancer	
	High Cholesterol			Lung Cancer	
	Uterine Cancer			Skin Cancer	
	Other Cancer				

Any other illnesses in the family not listed? _____

_____

SOCIAL HISTORY

Marital Status (circle one): Single Engaged Married Separated Divorced Widowed..

Highest level of education (circle one): <6th grade Jr. High High School College Graduate school Professional

Do you smoke currently? Yes No **If yes, how much:**_____

# of years smoking:_____ **Are you interested in quitting?** Yes No

If no, did you smoke in the past? Yes No **How many years:**_____ **How much:**____pcks/day

Are you exposed to smoke? Yes No

Any other tobacco use? Yes No **Type:** Cigars Chewing Tobacco Snuff Other

Do you drink caffeine? Yes No **If yes, how much?**_____

Do you drink alcohol? Yes No **What kind?** Beer Wine Liquor Other:_____

_____

If yes, how many times per week?_____month?_____year?_____

Have you ever had a problem with alcohol in the past? Yes No

Do you have a history of drug use? Yes No **What Type:**_____

CONSENT TO TREAT

I, or my legal guardian or parent, authorize Compass Family Medicine, PA, its providers or designated replacements to provide medical care deemed reasonable by today's standards.

Patient Name:_____ DOB:_____

Signature of Patient/Legal Guardian:_____

Date:_____

PATIENT CONSENT FOR USE AND DISCLOSURE

Our practice is dedicated to maintaining the privacy of your health information. In conducting your business, we will create records regarding you and the treatment and services we provide to you. We are required by the federal and state law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice.

We may use and disclose your health information the following ways:

- Health related benefits and services
- Release of information to healthcare responsible parties
- Treatment
- Payment
- Healthcare operations

We may also disclose your health information under the following circumstances:

- Public health risks
- Organ/Tissue Donor
- Health oversight activities
- Research
- Legal Proceedings

- Serious threat to health or safety
- Law enforcement
- Military/National Security
- Workers' Compensation
- Inmates
- Deceased patients

The individual is also provided the right to request how confidential communications be delivered:

I wish to be contacted in the following manner (check all that apply):

___Home
_____Okay to leave appt information
_____Okay to leave detailed information

___Work
_____Okay to leave appt information
_____Okay to leave detailed information

Other personswe may disclose information to:
Name:_____
Phone #:_____

_____Written Letter
_____Okay to leave appt information
_____Okay to leave detailed information

INFORMATION REGARDING THE FOLLOWING PAGES:

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: This page is to be signed by you, the patient, to ensure our office can receive medical information. The reason that it is apart of your packet is so that you can have it signed when you return the packet to the office staff. This ensures that we will have medical records from your previous physician. If you ever have to be taken to the emergency room, stay at a hospital for any period of time, go to a specialist, or any other situation where we would need to have information for our records; you will be asked to fill out the same form for the specified doctor.
Initial:_____

POLICIES AND CHARGES ACKNOWLEDGMENT AND CONSENT FORM: This form is for patients with any noted disability and requires assistance. This form is to be signed by the listed patient. When the patient signs this form, they are agreeing that the person specified on the page is allowed to receive the same information as the patient; this includes but is not limited to: receiving hard copies of lab results, X-rays, visit notes, immunization records, etc. This page also list the laws and the patients rights regarding the issue.
Initial:_____

COMPASS FAMILY MEDICINE, P. A. (CFM)

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(Print)Patient's Full Name:_____

Birth Date (Mo/Day/Year):_____ Social Security Number:_____

Street Address:_____

City, State, Zip Code:_____

Phone #:_____

I do hereby authorize_____**(Name of Company/Agency/Facility/Person)**

Street Address:_____ Phone:_____

City, State, Zip Code:_____ Fax:_____

To Release:

DATES OF SERVICE: _____

____ DISCHARGE SUMMARY ____ IMAGING & X-RAY REPORTS _____MEDICATION LIST

____ ECG/EEG/CARDIAC CATH ____ LAB/PATH REPORTS _____ ENTIRE RECORD

____ EMERGENCY REPORTS ____ PROCEDURE REPORTS _____ OTHER_____

____ HISTORY & PHYSICAL ____ IMMUNIZATION RECORD _____

___ I DO ___ I DO NOT authorize the release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

Records to be released to:

Compass Family Medicine

Street Address: 2605 Kinard St, Suite 208 City,State,Zip Code: Newberry, South Carolina 29108

Phone:1-803-276-4860 Fax: 1-803-276-2812

PURPOSE OF DISCLOSURE:

____ REFERRAL TO SPECIALIST ___ INSURANCE ____ WORKERS COMP ____ CHANGE OF PCP

____ DISABILITY ___ PERSONAL ____CONTINUING CARE ____ LEGAL

____OTHER (SPECIFY): _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized to be furnished may not condition its treatment of me on whether or not I sign the authorization.

Signature _____ Date _____

NOTE! IF YOU ARE FILLING THIS OUT FOR A NEW PATIENT APPLICATION PLEASE MAKE SURE TO PUT DOWN YOUR PRIMARY CARE DOCTOR AND NOT A HOSPITAL. IF THIS FORM IS LEFT BLANK YOUR APPLICATION WILL BE VOID.

Compass Family Medicine

Patient Code of Conduct & Responsibilities

Compass Family Medicine adopts this Code of Conduct in order to define acceptable standards of behavior for patients. This Code of Conduct and Responsibilities provide a procedure for action whenever there are grounds to suspect that a patient has engaged in disruptive or unacceptable behavior. All patients, as a condition of the their continued treatment by Compass Family Medicine, will abide by Compass Family Medicine's rules, regulations, policies, and all other lawful standards.

The code of conduct also applies to chaperones and caregivers who may bring the patient into the office for their appointments.

Code of Conduct

1. Patient will treat all staff members with respect with their words, body language, or gestures.
2. Patient will refrain from any form of violence(verbal, sexual, or physical) to any person. This includes sexual, ethnic, or other types of harassment whether verbal or physical in nature.
3. Patient will be honest and factual with all communication with the staff.
4. Patient will not intentionally damage equipment or property.
5. If the patient has a child with them the patient is responsible for the behavior of the child. Patient is expected to supervise the child at all times and not allow the child to damage equipment, climb on furniture, chew on equipment, or make a mess.
6. Patient will not show up under the influence to their appointments. If the patient does show up under the influence, they may be dismissed.
7. Patient will not contact members of Compass Family Medicine, or the family of employee's of Compass Family Medicine, on private social media or outside of the official lines of communication in regards to their medical health. Any attempt to try and bypass official lines of communication may be grounds for discharge.
8. Patients will not solicit money from staff or other patients.
9. Compass Family Medicine does not allow smoking, vaping, weapons, or illegal drugs in our office.
10. Patient will be considered Non-compliant for repeated and /or deliberate violation of the rules or policies of Compass Family Medicine. This may be grounds for dismissal.

Patient Responsibilities

1. You are expected to provide complete and accurate information including your full legal name, address, home, phone number, date of birth, Social Security number, insurance carrier, and employer if required.
2. You are expected to provide accurate information about your health and medical history. Including but not limited to present and past conditions, hospital stays, urgent care, medication updates by other providers, vitamins/ herbal products, and perceived safety risks.
3. You are responsible for asking questions when you do not understand information or instruction while at your visit. If you believe that you can not follow through with a treatment plan; you are responsible for telling the provider. You are responsible for the outcome if you do not follow the care, treatment, and service plan. Repeated occurrences of refusal to follow treatment plans will be considered non-compliance.
4. You are expected to actively participate in the maintenance of your health and keep your provider up to date on the effectiveness of your treatment.
5. You are expected to provide complete and accurate information about your health insurance coverage and to pay your bills in a timely manner. Refusal to pay co-pays, deductibles, or debts owed will be grounds for loss of services or discharge.
6. You have the have the responsibility to keep appointments, be on time, and call your healthcare provider if you can not keep your appointment. After neglecting to call ahead and cancel/ reschedule appointment 3 times patient will be considered for dismissal. (Patient should call at least 45 minutes before appointment so staff has the time to fill the spot with a walk-in or someone on the wait list)
7. For new patients: You are expected to fill out and sign a release of information when transferring care from another provider. This will allow us to obtain your medical records from them for continuity of care. Refusal to fill out this section with your primary care physician's information will disqualify your application.

I acknowledge that I have fully read and accept the code of conduct and responsibilities of Compass Family Medicine.

Signature _____ Date_____

Printed name _____ Date of Birth_____