

**ACCESS MEDICAL CENTER
3816 HIGHWAY 17 SOUTH
NORTH MYRTLE BEACH, SC 29582
843-272-1411**

Date: _____ Time: _____ Account#: _____ SSN: _____

PATIENT'S INFORMATION:

Mr/Mrs/Ms: Last: _____ First: _____ MI: _____

DOB: _____ Age: _____ Sex: F M

Address: _____

City: _____ State: _____ Zip Code: _____

H/Phone: _____ C/Phone: _____ Local #: _____

Email address: _____ (access/dermavogue use only)

REASON FOR VISIT: _____ IS IT WORK

RELATED?: Yes No

Employer Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Supervisor Name: _____

PERSON TO CONTACT IN AN EMERGENCY: _____

Relation: _____ Phone: _____

INSURED'S INFORMATION:

Name: _____ DOB: _____ SSN: _____

Ins. Co. Name and Address: _____

Phone: _____ ID#: _____ Group#: _____

What is your deductible amount? _____ Have you met that? Yes No

Please turn over and complete back portion.....

Please note that you are responsible for any copay, deductible, and/or percentage that your insurance does not pay. We are filing your insurance as a courtesy, this does not make us a provider therefore, you are responsible for all charges not covered by your insurance. Any outstanding balance is due immediately. Payment must be made on the day of your services for all owed amounts. If any unpaid balance goes past 60 days a collection fee will be calculated and added to the bill prior to going to collection agency. If you have any questions please bring those to our attention now. “We are not an urgent care facility.” If your insurance company has instructed you to go to an urgent care facility, you will need to go to the ER.

Payment is due at time of service:

_____ Cash _____ MC, Visa, Discover, Amex _____ Medicare

_____ Medicaid _____ Worker’s Comp

Patient or Guardian’s Signature: _____

Acknowledgment of receipt of Notice of Privacy Practices

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state laws, and outlining my rights regarding my health information.

Sign: _____ **Date:** _____

Relationship (if not signed by patient): _____

I wish to put the following restrictions on disclosure of my health information:

Internal use only

If patient/patient’s representative refuses to sign acknowledgment, please document date and time notice was presented to patient and sign below:

Presented on (date and time): _____

By (name and title): _____