Pinner Clinic, PA

A Rich History of Medical Tradition Since 1915

Carroll A. Pinner, III, MD   Benjamin C. Pinner, MD   Edwina Hallman, APRN

Dear Patient:

Welcome to Pinner Clinic! We are delighted that you have chosen us to be your primary healthcare provider. Each of our physicians and nurse practitioner are board certified in Family Medicine. We can care for you and your entire family, regardless of age or gender.

Our mission is to provide you with outstanding quality health care. To help us do this, we need certain information from you. ***Please complete the following forms (included in this patient welcome packet) and bring them with you to your first appointment**:*

1. Patient Demographic Sheet
2. Compound Authorization for Release (This form allows us to release information to a family member or friend)
3. Financial Policy
4. Receipt of Notice of Privacy Practices
5. Pinner Clinic Patient Health Assessment
6. Pinner Clinic PCMH Questionnaire
7. HIPAA Compliant Authorization for Release of Health Information (This form allows us to request your medical records from other physicians)

In addition to the completed forms, **please bring your driver's license/photo identification, insurance cards, and all current medications, supplements and vitamins you are taking** (bring original containers if possible). Please arrive 15 minutes prior to your scheduled appointment to give our front desk staff time to meet you and process your paperwork before your scheduled appointment time.

During your first visit, you will establish a relationship with one of our physicians whom you may have designated to be your primary care physician (PCP). After your first visit, we will make every effort to schedule you with your PCP when you call for an appointment. Our nurse practitioner works very closely and under the direction of our physicians. In the event your PCP is unavailable, and your medical problem is urgent in nature, one of the other physicians or the nurse practitioner will be available to address your needs.

It is our goal to be available when you need us. We have time allotted every day to work in patients who are sick and need to be seen quickly. If you do not have an appointment but would like to be seen, we encourage you to use our walk-in service. Appointments are not taken for the walk-in service, and you will be seen by the first available provider. If he/she is not your regular physician, please be assured he/she will have all the necessary information and full access to your medical record in order to make excellent decisions regarding your care.

We are open from 7:30 AM to 5:00 PM Monday through Friday.   Should you need care after office hours, there is always a provider on-call 24 hours a day, 7 days a week. We are also open every Saturday from 9:00 AM to Noon for urgent care needs.

If you have any questions, please do not hesitate to call us at 803-945-7475. We are here to help. Again, welcome to Pinner Clinic. We are happy to have you as a new member of our family and can't wait to meet you!

32 River Street ●   Peak, South Carolina 29122
(P) 803-945-7475 (F) 803-345-2832

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PATIENT INFORMATION
(PLEASE PRINT)

☐ Mr. ☐ Ms. ☐ Dr. ☐ Mrs. ☐ Miss	Patient's Last Name:	First:	MI:
Marital status: ☐ Single ☐Married ☐ Divorced ☐ Separated ☐ Widowed	Preferred Name:	Birth/Maiden Name:	
Birth Date:	Gender:	SSN:	Email Address:

Preferred Language:	Race:	Ethnicity:	Driver's License Number:	State:	Exp. Date:

Home phone:	Work phone:	Cell phone:	
Address:	City:	State:	ZIP Code:
Occupation:	Employer & Address:	Employer phone:	
Referred by:	☐ Dr.	☐ Patient	☐ Other

INSURANCE INFORMATION
(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person responsible for bill: (if self, please skip to Primary Insurance)	Is this person a patient at our practice? ☐ Yes ☐ No	
Date of Birth:	Address:	Home Phone:
Occupation:	Employer & Address:	Employer phone:

****Policy Holder's Name, SSN, Date of Birth and Relationship to Patient are <u>REQUIRED</u> to file all insurance claims.****

Primary Health Insurance Company:

*Policy Holder's Name:(as it appears on insurance card)	*SSN:	*Birth date:
Group Number:	Policy Number:	Co-Payment: $

*Patient's relationship to Policy Holder:	☐ Self	☐ Spouse	☐ Child	☐ Other

Secondary Health Insurance Company:

*Policy Holder's Name:(as it appears on insurance card)	*SSN:	*Birth date:
Group Number:	Policy Number:	Co-Payment: $

*Patient's relationship to Policy Holder:	☐ Self	☐ Spouse	☐ Child	☐ Other

IN CASE OF EMERGENCY (LOCAL FRIEND/ RELATIVE)

Name:	Relationship:	Phone #:	Alt. Phone #:
Name: (not living at same address)	Relationship:	Phone #:	Alt. Phone #:

The above information is true to the best of my knowledge. I authorize Pinner Clinic, P.A. or insurance company to release any information required to process my claims. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I understand payment is due at the time of service, and that Pinner Clinic reserves the right to dismiss patients that fail to keep their accounts current after reasonable attempts to collect payments have been made. I further agree to pay all reasonable costs and late fees should my account be turned over to collections.

Patient/Guardian Signature: ____ Date: ____________________

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COMPOUND AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient ____ Date of Birth:__________________

If we need to reach **you** during the day, what is the best **daytime** phone number?	Check the following information that can be provided by voice mail and/or text:
____	☐ Financial
	☐ Medical Information
Is this home, work or cell? ______________________	☐ Results of lab tests/x-rays
OK to leave voice mail messages? ☐ Yes ☐ No	☐ Appointment information
OK to send text messages? ☐ Yes ☐ No	☐ Other: _______________________________

***Pinner Clinic, PA** is authorized to release protected health information regarding the above-named patient to the entities named below. The purpose of this form is to strictly adhere to patient instructions.*

Person/Entity to Receive Information Provide information for each person/entity that you approve to receive your information.	**Description of Information to be Released** **Check each** that can be given to the person/entity indicated on the left
Name: ____ Best Daytime Phone: ___________________________ Voice mail messages ok? ☐ Yes ☐ No	☐ Financial ☐ Medical Information ☐ Results of lab tests/x-rays ☐ Appointment information ☐ Other: _______________________________
Name: ____ Best Daytime Phone: ___________________________ Voice mail messages ok? ☐ Yes ☐ No	☐ Financial ☐ Medical Information ☐ Results of lab tests/x-rays ☐ Appointment information ☐ Other: _______________________________

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Pinner Clinic, PA. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective moving forward from the date listed on the form. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

____ ____________________

Signature of Patient or Personal Representative   Date

____

Description of Personal Representative (Attach additional information as necessary)

This form will expire 1 year from the date listed on the form unless noted otherwise by patient. Form expiration date: ________________________

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Financial Policy

We are excited to be your Primary Healthcare Provider and thank you for putting your trust in Pinner Clinic. We are committed to the success of your medical treatment and care. Prompt payment of your charges help us keep our fees down, so please take a moment to familiarize yourself with our financial policies.

Insurance:

We participate with many insurance plans and will bill participating insurance companies as a courtesy to you. You are expected to pay your deductible or copayments at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you may be expected to pay the balance in full. You are responsible to be sure all charges are paid whether by you or by your insurance company. **If you need assistance or have questions, please contact our Billing Specialist 9:00 AM to 5: 00 PM, Monday through Friday, at 803-945-7475 ext. 103.**

Co-Pays, Deductibles, Co-Insurances, and Payments:

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and copayments for participating insurance companies. *Please remember patient responsibility amounts are determined by your individual insurance plans*, not Pinner Clinic. *If you are not covered by insurance at the time of service, please be advised that you will be responsible for all charges incurred at the time of service.*

For your convenience we accept **cash, checks, MasterCard, Visa, American Express, and Discover.** There is a $35.00 service charge for returned checks and your account will be put on a cash-only basis. Outstanding/ overdue balances are due within 30 days unless prior arrangements have been made with the billing department. If your balance is over 90 days, you will receive a final demand letter for payment. At that point, your account may be put in a hold status until further arrangements are made. **If you need assistance or have questions, please contact our Payment Specialist 9:00 AM to 5: 00 PM, Monday through Friday, at 803-945-7475 ext. 120.**

Non-Emergency Appointments:

We reserve the right to reschedule non-emergency appointments if there is an overdue balance on your account or if a co-payment is not made at the time of service.

Family Medical Leave Forms/Short/Long Term Disability Forms:

We understand that at times, various forms or letters may be required to assist you with your health care needs. Because these forms can be time consuming, each provider reserves the right to charge a fee for affidavits, letters, or forms that we prepare for legal or employment matters. Those fees are not billable to your insurance company or employer and are due at the time of service. An office visit/appointment may also be required depending on the nature of the form and information request. Please allow 5-7 business days for completions of requested forms/letters.

Financial Policy, Continued

Refunds:
If you have a credit on your account, we will gladly refund the amount within thirty days of your request (and if cleared by the Billing Department), or we can apply the credit to your account. You must provide a correct mailing address where your refund is to be sent.

Dismissal Process:
There are several reasons that a patient may be dismissed from our practice. A few reasons are as follows:

- Failure to keep scheduled appointments
- Being verbally or physically abusive to staff
- Abuse of prescription drugs and/or failure to adhere to Pinner Clinic's narcotic policy
- Failure to meet financial obligations

A certified letter will be sent to your last known address notifying you that you are being dismissed from our practice. If you have a medical emergency within thirty days of the dates of the letter, one of our providers will be available for advice. After thirty days, you will no longer be seen at our practice by any provider. A copy of your medical records may be forwarded to your new doctor after a formal request is made.

Financial Policy Acknowledgement

Please do not sign this form unless you have read the Financial Policy.

Patient Acknowledgement: I, _______________________________, have read, understand, and agree to Pinner Clinic, PA's Financial Policy. I agree to pay for services rendered at the time of service. I also understand that Pinner Clinic, PA reserves the right to dismiss patients that fail to keep their accounts current after reasonable attempts to collect payments have been made. I also understand the terms of this Financial Policy may be amended by the practice without prior notification to the patient or guarantor due to changes in regulations or practice operations.

____

Patient/Guardian Signature Date

You may review this Financial Policy at www.pinnerclinic.com

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Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been given a copy of Pinner Clinic's Notice of Privacy Practices, and further understand that any questions may be directed to the Privacy Officer/Practice Administer at Pinner Clinic.

____
Patient Printed Name

____
Patient Signature

____
Date

PINNER CLINIC, PA
PATIENT HEALTH ASSESSMENT

Patient Name (PLEASE PRINT):______________________________

Today's Date: ____________ **DOB:** ______________ **SS#:** ________________

DRUG ALLERGIES: Please list ALL medications you are allergic to.

1. ____________________ 3. ____________________ 5. ____________________

2. ____________________ 4. ____________________ 6. ____________________

PREVIOUS MEDICAL ILLNESSES: Please check any illnesses you have had in the past.

- ☐ Anemia / Low Blood
- ☐ Anxiety
- ☐ Asthma
- ☐ Bleeding from Bowels
- ☐ Bleeding Problems, Type: ____________
- ☐ Blood Clot in Leg
- ☐ Blood Clot in Lung
- ☐ Blood Transfusion
- ☐ Cancer, Type: ______________________
- ☐ Communicable Disease, Type: ________
- ☐ Congestive Heart Failure
- ☐ Depression
- ☐ Diabetes / High Blood Sugar
- ☐ Emphysema / Chronic Bronchitis
- ☐ Epilepsy / Seizures
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hepatitis/Liver Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Irregular Heart Beat
- ☐ Kidney Disease, Type: __________
- ☐ Kidney Stones
- ☐ Prostate Problems
- ☐ Rheumatic Fever
- ☐ Skin Disease, Type: ________
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers in Bowels / Stomach
- ☐ Varicose Veins or Spider Veins
- ☐ Other: ________________________
- ☐ Other: ________________________
- ☐ Other: ________________________
- ☐ Other: ________________________
- ☐ Other: ________________________
- ☐ Other: ________________________
- ☐ Other: ________________________

SURGICAL HISTORY: Please provide dates for any surgeries you have had.

SURGERY	DATE
Appendectomy	
Joint Scope Surgery	
Biopsy	
Open Heart Surgery	
Neck Artery Surgery	
Cataract Surgery ☐ R ☐ L	
Gallbladder	
Broken Bone Repair	
Joint Replacement	

SURGERY	DATE
Back Disc Surgery	
Abdominal Surgery	
Tonsils Removed	
Prostate Surgery	
Vasectomy	
Tubal Ligation	
Hysterectomy (Complete? ☐ Y ☐ N)	
Mastectomy ☐ R ☐ L	
Other: ______________________	

CONTINUE to Next Page..

PINNER CLINIC, PA
Patient Health Assessment

Patient Name : ____ **DOB:** ______________________

CURRENT MEDICATIONS: Please list ALL medications you are currently taking. Include dosage and how often you take each medication.

MEDICATION (including over-the-counter)	DOSAGE	HOW OFTEN DO YOU TAKE?

IMMEDIATE FAMILY HISTORY: Check beside any disease that has affected your mom, dad, brothers, and/or sisters.

☐	Heart Attack	☐	Osteoporosis	☐	Cancer, Type:
☐	High Blood Pressure	☐	Stroke	☐	Alcohol Abuse
☐	High Cholesterol	☐	Epilepsy / Seizures	☐	Anxiety or Depression
☐	Asthma	☐	Bleeding Problems	☐	Glaucoma
☐	Tuberculosis	☐	Sickle Cell Anemia	☐	Other:
☐	Liver Disease	☐	Diabetes / High Blood Sugar	☐	Other:
☐	Kidney Disease	☐	Thyroid Problems	☐	Other:

SPECIALISTS YOU ARE CURRENTLY SEEING:

Specialty	Specialist's Name	Location/Address	Phone Number

CURRENT HEALTH HABITS:

How often do you exercise? ☐ Never ☐ Occasionally ☐ Several Times Per Week ☐ Every Day

Have you ever smoked? ☐ Yes ☐ No

Number of Years: _____

How much do you/did you smoke every day? ____ # Cigarettes ____ #

Do you use any of the following tobacco (other than cigarettes)?

☐ Pipe ☐ Snuff ☐ Cigars ☐ Chewing Tobacco ☐ Dip ☐ Electronic Cigarettes ☐ Vapor

PINNER CLINIC, PA
PATIENT HEALTH ASSESSMENT

Patient Name : ____ **DOB:** _____________________

Females ONLY:

Are you pregnant or planning to be pregnant soon? ☐ Yes ☐ No

Currently breast feeding? ☐ Yes ☐ No

Number of: Pregnancies? ____ Miscarriages? ____ Deliveries? _____

Have you ever had postpartum depression? ☐ Yes ☐ No ☐ Not Sure

Current form of birth control: ______________________

Date of most recent: Pap smear? _______________ **Mammogram**? _______________

Any abnormal results? ______________

Date of most recent menstrual period: _____________________

Pinner Clinic Patient Centered Medical Home (PCMH) Questionnaire

Please answer as many questions as you can. Circle your answers and add comments if desired.
Your care team will be able to help answer any questions you may have.

DATE: _____________PATIENT NAME: ____________________________________DOB: _______________

1. Tobacco Smoking Status:	Never / Former / Some Days / Everyday
2. If you smoke, describe how much you smoke:	____________________
3. Smokeless tobacco status:	Pipe / Snuff / Cigars / Chewing Tobacco, Dip / Electronic Cigarettes, Vapor
4. Tobacco-years of use:	___________________
5. E-cigarette/vape status:	Never/Former/Current
6. Most recent tobacco use screening:	___________________
7. Do you have Advanced Directives in place?	Yes / No
8. Do you have a Medical Power of Attorney?	Yes / No
9. What is your current alcohol intake?	None / Occasional / Moderate / Heavy
10. Describe your current caffeine intake:	None / Occasional / Moderate / Heavy
11. Have you had any recent changes in family or social situations?	Yes / No
12. Describe your general stress level:	Low / Medium / High
13. Do you live alone or with others?	Alone / With Others
14. Are you exposed to passive (secondhand) smoke?	Yes / No
15. How would you describe the condition of your mouth and teeth, including false teeth or dentures?	Excellent / Good / Fair / Poor
16. How often do you see or talk to people that you care about and feel close to?	________days a week
17. In the past year, have been unable to get medicine or medical care when it was really needed?	Yes / No
18. Do you have any family members with known mental health conditions?	Yes / No
19. Do you have any family members with known alcohol abuse?	Yes / No
20. Do you have any family members with known drug abuse? (Prescription/Non-Prescription)	Yes / No
21. Do you have any known mental health conditions?	Yes / No
22. Support systems or programs currently being used?	Yes / No
23. Are you legally blind in one or both eyes?	Yes / No
24. Are you hard of hearing or deaf in one or both ears?	Yes / No
25. Are able to care for yourself?	Yes / No
26. Do you have difficulty concentrating, remembering, or making decisions?	Yes / No
27. Do you have a caregiver?	Yes / No
28. Describe your activity level:	None / Occasional / Moderate / Heavy

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: ___________________________________ Date of Birth: _________________________

Previous Names/s: ________________________________ Social Security Number: __________________

I Authorize: Name of Designated individual, Organization, or Provider:

____

Address: ____

Phone Number: ______________________________ Fax Number: _______________________________

TO: Release my health care information to (Name of Designated individual, Organization, or Provider):

Pinner Clinic, PA
32 River Street
PO Box 99
Peak, SC 29122
P: (803) 945-7475 F: (803) 345-2832

for the purpose of Medical Care or Other: ____

Information to be Released:

☐ All Medical Records

☐ All Medical Billing Records

☐ X-Ray and Imaging Reports

☐ Other: ____

Dates of Treatment:

☐ All Dates

☐ Specific Dates: ______________ to ______________

1. I understand that my express consent is required to release any health care information relating to testing/diagnosis, and/or treatment for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.
2. I understand that authorizing the disclosure of this health information is voluntary and you have my consent to release medical records for all dates including all diagnostic tests of any type and reports, history, hospitalization, diagnosis, prognosis, treatment, medication and pharmacy records, correspondence, consults, statement of charges or expenses. Any and all reports of any type or character.
3. I understand I have the right to revoke this authorization in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. To revoke an authorization, I may fill out a revocation form available at the facility/Provider or write a letter to the facility/Provider.
4. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.
5. I understand that the information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.
6. I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment).
7. This authorization will expire 90 days from the date signed. A copy or facsimile of this authorization shall be counted true and valid as original.

____ ____________________
Signature of Patient or Legal Representative — Date

____ ____________________
Legal Representative Printed Name — Relationship to Patient