Curtis Haskins, MD
curtishaskinsmd.com

6650 Rivers Avenue
North Charleston, SC 29406

Phone: 843-494-2411
843-576-5417
Fax: 843-410-2790

NEW PATIENT HISTORY FORM

Date: _____

Name: _____ **Age:** _____ **DOB:** _____ **Sex:** M F

Address: _____

_____

Reason for Visit: _____

Phone number: _____

Email: _____

Emergency Contact Information: (please provide name, address, and phone number)

_____

_____

_____

PAST MEDICAL HISTORY

Have you ever had any of the following?

Check each item	No	Yes	Check each item	No	Yes	Check each item	No	Yes
Anemia/Blood Disorder			Gallstones			Lung Problems		
Anxiety			Gout			Neurological Disorder		
Arthritis			Headaches			Pneumonia		
Asthma			Heart Attack			Seizure Disorder		
Back/Neck Problems			Heart Valve Problems			Skin Disorder		
Blood Clotting Disorder			Hepatitis			Stomach/Intestine Ulcer		
Cancer			High Blood Pressure			Stroke		
Coronary Artery Disease			High Cholesterol			Thyroid Disorder		
Depression			Kidney Disease			Tuberculosis		
Diabetes			Liver Problems			Other:		

Explanations for "Yes" answers:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Are you? ☐ Right-handed ☐ Left-handed

Are you or have you ever been under care for pain management? ☐ No ☐ Yes

If Yes, ☐ Currently ☐ In the past

Pain Management Provider: _____

HOSPITALIZATIONS: ☐ None Year Hospital

Illnesses: _____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Surgeries: _____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

HEALTH MAINTENANCE:
Have you ever had the following?

	Yes/No	Year	Results	Doctor
Cardiac Stress Test				
Colonoscopy				
Mammogram				
Pap Smear				
Bone Density Test				
Chest CT (if any history of smoking)				
Hepatitis Testing				
Tuberculosis				
Last Dental Exam				
Last Eye Exam				
Last Skin Exam				

IMMUNIZATIONS:

All childhood immunizations completed? ☐ **No** ☐ **Yes**

Check each item	No	Yes
Pneumonia		
Shingles		
Tetanus Shot		
Flu Shot		
Chickenpox (or had the disease)		
HPV		

CURRENT MEDICATIONS: *(Include over-the-counter, supplements, and "as needed" meds)*

Medication Name	Strength	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

If additional space is needed, please attach on another piece of paper.

MEDICATION ALLERGIES:

Medication Name	Reaction
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

FOOD & ENVIRONMENTAL ALLERGIES: (*Please list)*

_____

FAMILY HISTORY:

	No	Yes	Family Member(s)		No	Yes	Family Member(s)
Anesthesia Problems				High Blood Pressure			
Bleeding Problems				Osteoporosis			
Cancer Location:				Stroke			
Diabetes				Thyroid Disease			
Heart Disease prior to age 60				Other Disease			

SOCIAL HISTORY:

Employer Name: _____ Phone: _____

Employer Address: _____

_____

Occupation: _____ ☐ Retired ☐ Disabled ☐ Unemployed

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Number of Children: _____ Hobbies: _____

PERSONAL HABITS:
Do you…

Check each item	No	Yes	How much?	How long?
Exercise regularly?				
Use alcohol?				
Wear a seat belt?				
Use illegal drugs?				
Ever smoked?				

Do you have a Healthcare Power of Attorney? ☐ No ☐ Yes

Please list your preferred pharmacies:

Primary Pharmacy:
Name: _____

Address: _____

_____

Phone Number: _____

Secondary Pharmacy:
Name: _____

Address: _____

_____

Phone Number: _____

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

Please circle Yes or No for the following three (3) questions:
May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:
_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

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Financial Policy

As a result of our sincere desire to base all medical decisions on what is best for you, the patient, not what is best for the insurance company, we do not contract with any insurance carriers. Our contract is with the patient… YOU. Every patient is valued at this office. We strive to provide value as well as excellent medical care. We offer more convenience, spend more time with our patients, and offer the most cost effective excellent medical care available. We charge less than 50% of a traditional office visit.

1. **All charges must be paid at the time of service** and our treatment fees are the same for all patients, regardless of insurance coverage, or lack thereof.

2. The contract with your insurance company to pay for a portion of your medical care is between you and your insurance company. By eliminating costs associated with billing, coding, referrals, authorizations, payment delays, EOB reviews, claim denials, re-submissions, collection risks, and other managed care costs, we can provide patients a fair price for services without the administrative hassles and bureaucracy.

3. For your benefit, we will provide you with our fees and billing codes, upon request, before any services are performed. We recommend you contact your insurance carrier to verify your benefits so you will have a basic understanding of how your insurance will reimburse you for services provided by our office. Unfortunately, insurance carriers are not always willing to provide their allowable fees or disclose which billing codes they will cover. If this is the case, you may want to contact the SC Department of Insurance - http://www.doi.sc.gov.
NOTE: Dr. Haskins has chosen to "opt out" of Medicare. All patients who are on Medicare, or are eligible for Medicare, must sign the federally mandated "Private Contract" in order to receive services at our practice. All service fees must be paid at the time of service and neither Dr. Haskins nor the patient may file a claim to Medicare for reimbursement.

4. If requested, you will be given a completed claim form with all the codes necessary for you to file a claim with your insurance carrier. We recommend you contact your insurance carrier, or search their website, to learn how to file your claim.

5. Due to rising administrative costs and the numerous requests we receive, our office does not fill out “forms” from insurance companies. A copy of the patient’s medical records will be forwarded to the insurance company when a signed authorization to release medical records is received. Their medical review professionals can extract the information required from these records.

6. Please Note: We do not charge interest, therefore, we are unable to offer in-house financing or payment plans. If you are unable to pay for your services in full with cash or money order, you may put the balance on your credit card.

7. Medicare: Dr. Haskins has chosen to "Opt Out" of Medicare. All patients who are on Medicare, or are eligible for Medicare, must sign the federally mandated "Private Contract" in order to receive services at our clinic. All services must be paid at the time of service and neither Dr. Haskins nor the patient may file a claim to Medicare for reimbursement.

8. Medicaid: We do not process Medicaid patients. We only accept “Private Pay” patients. We will not file any claims to Medicaid for reimbursement of your medical services.

9. ACA Exchange Plans:
We are not contracted with insurance of any kind. Again, we only accept “Private Pay” patients. We will not file claims to your insurance company for reimbursement of your medical services now or in the future.

10. Champus/Tricare: We are not an active Champus/Tricare/Tricare for Life provider. We will NOT accept Champus/Tricare/Tricare for Life insurance; we will NOT file any claims to Champus/Tricare/Tricare for Life, and we will NOT accept the Champus/Tricare/Tricare for Life fee schedule for reimbursement of our services.

11. **All Patients (please check Yes or No for all three (3) of the following questions):**

[ ] Yes [ ] No My current symptoms are related to an accident/injury.

[ ] Yes [ ] No I am currently being represented by an attorney and/or I am currently under worker compensation care.

[ ] Yes [ ] No I may seek an attorney/workers compensation benefit in regards to this accident/injury.

ALL charges for attorney cases, workers compensation cases, accident and/or injury cases must be paid in full, in advance, unless an agreement between Dr. Haskins and your attorney has been worked out ahead of time. We will not file any claims for insurance benefits/reimbursement and we will not provide any discounts/write-offs for insurance or workers compensation plans. Our charges are already less than 50% of a traditional office visit. By signing this document, you are agreeing to pay for our services in full and forego any insurance benefits/discounts. I have read, understand, and agree to the terms and conditions listed above.

_____
Printed Name of Patient or Parent if Patient is a Minor

_____ _____
Signature of Patient or Parent if Patient is a Minor Date

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PRACTICE POLICIES

Please read these policies carefully. We understand that there is a lot of information here, but the more you know about this type of medical practice, the more you will benefit from our patient-centered approach.

Scheduling Appointments

Patients are generally seen by appointment only. We schedule 8-10 appointments per day with some additional ***open appointments*** available for those who call in with issues that cannot be handled with a telemedicine/phone visit.

In most cases, we will be able to see you the same day or next business day.

Please help us maintain a **timely schedule** by:

- Arriving 15 minutes prior to your appointment to complete any necessary paperwork. To accommodate you more efficiently, please download the appropriate forms from this site, complete them to the best of your ability and bring them with you to your appointment. Please call if you are running late. Please understand that your appointment time cannot be extended due to a late arrival.

- Calling the office first to schedule an **open appointment** versus walking in

- Bringing your medications, or an updated list with dosing, to each visit

Telemedicine/Phone Visit Policy

It can be very difficult to recognize and treat illnesses over video/phone. The best attention and treatment are always delivered in person. Open appointments allow for this. However, if you feel you have a *single, simple problem* and understand the limitations of "telemedicine", Dr. Haskins will be happy to discuss your issue with you. Please realize that time for discussion on the video/phone, documentation in the chart, and calling in a medication(s) to your pharmacy takes valuable time and, thus, you will need to pay a $200 fee at the time of service. To connect with Dr. Haskins via video, click on the “Telemedicine” tab at the top of the page of our website at **curtishaskinsmd.com**. Click on the “Pay now by clicking HERE” button, enter your card information, then click on the link in the center of the Telemedicine page to sign in.

In the interest of patient safety and responsible medicine, telemed/phone visits are available only to established patients of Curtis Haskins, MD. In most circumstances, controlled substances will not be prescribed for phone visits.

Cancellation/No-Show Policy
Your appointment time is reserved especially for you. If you are unable to keep your appointment, please call to cancel at least 24 hours prior to your scheduled time. This allows us to offer that time to another patient. If a patient fails to show for his/her appointment and does not call in an appropriate amount of time, there will be a $50 fee charged to the account. Patients who consistently fail to keep their appointments, without proper notice, will be dismissed from the practice.

After Hours and Emergency Access
If you have a life-threatening medical emergency, please call 911 immediately. Dr. Haskins can be reached after hours by leaving a message on the (urgent) voice-mail line. This is only for medically urgent, non-life-threatening issues that cannot wait until the next business day. This is a service available to ***established*** patients of the practice only. Most importantly, never delay emergency treatment while waiting for a call back from the after-hours line.

All non-urgent issues should be addressed by calling the office number, where a message can be left anytime. During the times when Dr. Haskins may be out of town, or otherwise unavailable, urgent patient issues will be forwarded to another physician with whom Dr. Haskins has arranged coverage.

Inpatient Hospital Coverage
In the event you need to be admitted to the hospital, Dr. Haskins will use the hospitalist service of the hospital that you choose.

Insurance Plans Accepted
Curtis Haskins, MD is a direct-pay/cash friendly practice. *We do not accept insurance of any kind.* However, please bring your insurance card with you for us to copy in the event we need this to help you. Not accepting insurance saves us time and money allowing us to offer you a higher level of personal service than what you can receive at a traditional practice.

Financial/Payment Policy
Payment-in-full is due at the time of service. We accept Visa, MasterCard, Discover, Apple Pay and Google Pay, as well as Health Savings Account (HAS) cards for your convenience; and, of course, cash. Sorry, we cannot accept checks.

Prescription Refill Policy
The best time to request prescription refills is during an office visit. Generally, Dr. Haskins will provide you enough refills to cover you until your next appointment. The task of documenting, calling and faxing pharmacies to refill prescriptions is very time-consuming. If your current prescription bottle indicates that you have remaining refills, please contact your pharmacy. Requests from the pharmacy to renew an expired prescription will require 24 hours to process, if granted. If requests are received after 12:00 noon on Friday, please be aware that these requests may not be called into the pharmacy until the following Monday. You may leave after-hours requests on the voice mail, but the same turn-around time will apply.

Please do not call Dr. Haskins after hours for refill requests.

Opioids and Controlled Substances Policy
Many patients have been treated with controlled substances for management of chronic pain. The goal of this treatment is reduction of pain to a level that allows an improved ability to function and a better quality of life. Every patient in this situation will be asked to complete a pain contract. **Early refills of controlled substances will not be allowed.**

Form Completion Policy
Due to high administrative costs and the large amount of time required to complete the multitude of forms from the many different insurance companies, Dr. Haskins does not do this. He believes his time is better spent taking care of his patients. Instead, Curtis Haskins, MD will provide your insurance company with a copy of your medical records when a signed authorization is received. Their medical review professionals can extract the required information from your records.

Other Non-Covered Services:

- **Missed appointments:** Failure to notify us at least 24 hours in advance that you will not be able to keep your appointment will incur a $50 missed appointment charge. Any exceptions to this policy will be made on a case-by-case basis.

- **Medical Records:** Upon written request, a paper or electronic copy of your medical records can be provided to you. There will be a $15 base charge plus $0.50 per page for copies of your medical records.

- **After-hours appointment:** $50.00 in addition to the regular visit charge.

- **Telemedicine/Phone visit:** $200.00.

Grounds For Termination of Patient-Physician Relationship
Patients who consistently miss appointments without proper notice, disregard the stated policies of the practice, or act in a way that is deceptive, dishonest, or abusive will be dismissed from the practice with 30 days written notice. During this time, Dr. Haskins will be responsible for responding to urgent medical matters only.

Please sign this document below and bring it with you to your New Patient Appointment. Please do not hesitate to contact the office if you have questions about the content of our policies.

_____ _____ _____
Signature Printed Name Date

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AUTHORIZATION FOR RELEASE OF INFORMATION / PRIVACY POLICY

Patient Name: _____ DOB: _____

Curtis Haskins, MD is authorized to release protected health information (PHI) to include lab results, x-ray results, appointments, referrals, and diagnosis and treatment options about the above-named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information Check each person/entity that you approve to receive information.	**Description of Information to be released** Check each that can be given to person/entity on the left in the same section.
□ Voice Mail	□ Lab results □ X-ray results □ Appointments □ Referrals □ Diagnosis and treatment options
□ Spouse (provide name & phone number)	□ Lab results □ X-ray results □ Appointments □ Referrals □ Diagnosis and treatment options
□ Parent (provide name & phone number)	□ Lab results □ X-ray results □ Appointments □ Referrals □ Diagnosis and treatment options
□ Other (provide name & phone number)	□ Lab results □ X-ray results □ Appointments □ Referrals □ Diagnosis and treatment options

Email and Voice Mail Messages
I understand that if I choose to communicate personal health information by email to or from Curtis Haskins, MD, I must accept any risk associated with that action, and I will NOT hold Curtis Haskins, MD or its staff responsible for any disclosure of that information. I also understand that:

- Email is a convenience and not appropriate for emergencies or time-sensitive issues.
- Email may not be reviewed every day.
- No one can guarantee the privacy of email messages. Email transmitted to or from a patient will NOT be encrypted.
- Highly sensitive or personal information should not be communicated via email.

Email Address: _____

Patient/Legal Guardian Signature: _____ Date: _____

Patient Information

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. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure 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 conditional on signing. This authorization shall be in effect until revoked by the patient.

Date: _____

_____
Signature of Patient or Personal Representative

_____
Description of Personal Representative's Authority (attach necessary documentation)

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MEDICAL INFORMATION REQUEST / RELEASE

Date: _____

Addressed To: _____

_____

In Reference to Patient:

_____ _____
Name **DOB**

The listed patient requests the release copies of:

☐ All Medical Records ☐ Radiology Reports ☐ Hospital Summaries

☐ Electrocardiograms ☐ Laboratory Reports ☐ Other: _____

Dated from _____ to _____

I hereby authorize the release of the indicated medical information:

Please send it promptly via: ☐ Fax ☐ Mail ☐ Email ☐ Other: _____

Note: If faxing or emailing records, privacy cannot be guaranteed.

Please release this information to:

Curtis Haskins, MD
Fax: 843-410-2790

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that this authorization may be revoked in writing by me and delivered to the Privacy Contact of Curtis Haskins, MD at any time, although revocation will not be effective as to the disclosure of records whose release I have previously authorized or where other action has been taken in reliance on an authorization I have signed.

I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by any recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

_____ _____
Patient Name or Authorizing Representative **Relationship of Representative**

_____ _____
Patient or Authorizing Representative Signature **Date**

_____
Witness

Expiration Date: This authorization will expire on (date or event) _____
If no date or event is stated, expiration is six (6) months from the date it was signed.
*Copy Provided: The (covered entity) shall provide a copy of this authorization, when signed, to the subject individual.

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Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information

Card Type: ☐ **MasterCard** ☐ **Visa** ☐ **Discover** ☐ **AMEX**
☐ **Other** _____

Cardholder Name [as shown on card]: _____

Card Number: _____ **CVV Code:** _____

Expiration Date [mm/yy]: _____

Cardholder ZIP Code [from credit card billing address]:_____

I, _____, authorize Curtis Haskins, MD
Print Name on Above Line
to charge my credit card above for agreed upon medical services. I understand that my information will be kept on file for future services/office visits.

_____ _____
Patient or Representative Signature **Date**