LAKE CITY FAMILY MEDICINE, LLC
Morris E. Brown, III, MD FAAFP
Shafara Dozier Douglas, PA-C

901 N. Matthews Road
Lake City, SC 29560
Phone: (843) 374-8380
Fax: (843) 374-5247

Patient Name:		**Social Security #:**	
Address:		**P.O. BOX:**	
City, State, Zip:		**Home Phone:**	**Work Phone:**
County	**Date of Birth:**	**Sex:** Male Female	**Martial Status:** Single Married Divorced Separated Widowed
Other phone:	**Race:** Black White Hispanic Asian Indian	**Ethnicity:** Hispanic Non-Hispanic Other	
Previous Physicians		**Current Physician/Specialists:**	

INSURANCE INFORMATION

Insured Name:	**Social Security Number**	**Date of Birth:**
Insurer's ID#	**Group/Plan#:**	**Relationship to patient:**
Insurer's Employer:	**City, State, Zip:**	**Phone:**

EMERGENCY CONTACT INFORMATION

Emergency Contact Name:	**Phone Number:**	**Address** **City, State, Zip:**
Additional Contact Name:	**Phone Number:**	**Address** **City, State, Zip:**

"I authorize any holder of medical or other information about me to be released to the Social Security Administration or its intermediaries or carriers, the Department of Social Services or its contractor, Blue Cross and Blue Shield of South Carolina, and any commercial insurance company any information needed for this or a related Medicare, Medicaid, Blue Shield, Champus, Champ-VA or any commercial insurance claim. A copy of this authorization can be used in place of the original and request payment of medical insurance benefits to the party who accepts assignments on claim."

I acknowledge that I am responsible for payment of the bill. If for any reason a portion of my bill is not paid by my insurance, I agree to make arrangements for prompt payment of my bill.

Patient's/Guardian's Signature **Date**

HIPPA

Request for authorization for disclosure of Protected Health Information to a family member, friend or caregiver.

Date:	Patient Name:	Patient DOB:
Authorized Person(s):		
Comments:		
Patient Signature: (guardian signature)		
Witness:		

CONSENT FOR TREATMENT
ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

CONSENT FOR TREATMENT: I hereby give my consent for the treatment of the below named patient to Lake City Family Medicine, LLC under the care of the attending physician, his associates, partners, assistants, or designees. I consent to any healthcare which may encompass necessary laboratory, diagnostic, or medical treatment which my physician, his associates, partners, assistants, or designees may deem necessary or advisable.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES: I have been presented a copy of Lake City Family Medicine, LLC's notice of privacy practices. I have been provided the opportunity to ask questions about Lake City Family Medicine, LLC's privacy practices. I have also been given information requesting special handling/accommodations concerning privacy and use and disclosures of my protected health information.

If I have any questions regarding the information set forth in Lake City Family Medicine, LLC's notice of privacy practices, I will contact Lake City Family Medicine, LLC at 843-374-8380.

_____
signature of patient or authorized person

_____
relationship if other than patient

_____
witness

_____
date