F. Marion Dwight, MD, PA • Bamberg Family Practice

Patient Information			
Name:	Date of Birth: _____/_____/_____		
Mailing Address:	City:	State:	Zip Code:
Social Security Number: _____-_____-_____	Gender at Birth: ☐ Male ☐ Female		
Home Phone:	Cell Phone:		
*Bamberg Family Practice may leave appointment information (lab/x-ray results, &/or other correspondence on my): Voice Mail (circle one): Yes / No			
Race:	Email:		

Parent/Guardian (Responsible Party) Information			
Name:	Date of Birth: _____/_____/_____		
Mailing Address:	City:	State:	Zip Code:
Home Phone:	Cell Phone:		
Race:	Email:		

Insurance Information
****Please Provide a copy of all insurance cards to receptionist when checking in & with each visit****
Name of Insurance:
Insurance number or member ID:
Policyholder's name:
Policyholder's Date of Birth:_____/_____/_____
Relationship to Patient (circle one): self spouse mother father other:_____

*We accept insurances including Medicaid, Medicare and Children's Health Insurance Program (CHIP). A discounted/ sliding scale fee schedule is available based on family size and income.

Emergency Contact Information

I, the Patient or the Patient's Responsible Party, hereby authorize Bamberg Family Practice to release **ANY/ALL** Protected Health information (both electronically &/or hard/paper copies) to the following person(s) named below unless otherwise specified:

Name:________________________ **Relationship:**________________ **Phone:**______________________

If you do **not** wish for **ANY/ALL** information to be released to the person listed above then please circle the following information you wish to be released.

Family/Billing/Financial - **ONLY** Medical - **ONLY**

Name:________________________ **Relationship:**________________ **Phone:**______________________

If you do **not** wish for **ANY/ALL** information to be released to the person listed above then please circle the following information you wish to be released.

Family/Billing/Financial - **ONLY** Medical - **ONLY**

Name:________________________ **Relationship:**________________ **Phone:**______________________

If you do **not** wish for **ANY/ALL** information to be released to the person listed above then please circle the following information you wish to be released.

Family/Billing/Financial - **ONLY** Medical - **ONLY**

Rights of the Patient: I understand that I have the right to revoke this authorization at any time & that I have the right to inspect the Protected Health information to be disclosed as described in this document by sending written documentation to F. Marion Dwight, MD, PA (Bamberg Family Practice). I understand that a revocation is not effective in cases where this information had already been disclosed but will be in effect going forward. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient & may be no longer protected by federal &/or state law. I understand that I have the right to refuse to sign the authorization & that my treatment will not be conditional upon signing. This authorization shall be in effect until revoked by me, the patient &/or my responsible party.

Name (Printed):____________________________________ **Signature:**______________________________

Date:______________________

Authorization for Release of Medical Information for Payment & Treatment: I authorize F. Marion Dwight, MD, PA (Bamberg Family Practice) to release any information (including medical information) for insurance or third-party payer claim(s) submissions &/or payment for services. I also authorize those benefits from the insurance company of any third-party payer be paid directly to F. Marion Dwight, MD, PA (Bamberg Family Practice). I guarantee payment in full to F. Marion Dwight, MD, PA (Bamberg Family Practice) for the amount due upon completion of services. I also acknowledge that I am responsible for any/all services &/or treatments not covered by my insurance & agree to pay my balance in a timely manner. I authorize the release of my personal medical information for the purpose of providing, coordinating, & managing my health care, this includes (but is not limited to) the coordination of management of my health care with a third party such as another physician or health care agency. I do hereby voluntarily consent to such diagnostic procedures, hospital care, medical, & surgical treatment by F. Maron Dwight, MD, PA (Bamberg Family Practice) physician(s), physician assistants, nurse practitioner(s), nurses, medical assistants, or physician's designees as is necessary in his/her judgement. I acknowledge that no guarantees have been made to me as the result of treatments or examinations in the facility.

Name (Printed):____________________________________ **Signature:**______________________________

Date:______________________

F. Marion Dwight, MD, PA • Bamberg Family Practice

General Medical Information

Patient Name: _____ Date: _____

Date of Birth: _____

Why do you want to become a patient (i.e. uncontrolled blood pressure, diabetes, copd, ms, new to the area...etc.)? _____

_____

Medication List *(Prescription including Opioids/Narcotics, Over the Counter, &/or Herbal):**

Please List the Name, Dose, & Frequency (how often you take it) of each medication

- _____/_____
- _____/_____
- _____/_____
- _____/_____
- _____/_____
- _____/_____
- _____/_____
- _____/_____

Allergies (Medication, Food, Animal):

- _____/_____
- _____/_____
- _____/_____
- _____/_____

Social History:

*Please note that it is very important that you fill this out truthfully. We cannot adequately treat you if we do not know your history. *

- **Tobacco Use** (List All Products, this includes Vaping Devices)
  - _____
- **Alcohol Use** (List Any/All Alcoholic Products & how often you use them)
  - _____
- **Drug Use** (List Any/All Illegal Drug Use. Also, the use or over use of medications prescribed to you &/or medications prescribed to others)
  - _____

F. Marion Dwight, MD, PA • Bamberg Family Practice

Number of Children: _____ Marital Status: _____

Work History: ☐ Disabled ☐ Homemaker ☐ Retired ☐ Student

Are You currently Employed: ☐ Yes ☐ No

Occupation/Job: _____ Type of Work: _____

Family Medical History: Have your Family Members experienced the following problems? (Check All that Apply)

Illness/Medical Issue	Mother	Father	Siblings	Other Family Members
Arthritis				
Asthma				
Bleeding Disorder				
Cancer				
Diabetes				
Heart Disease				
High Blood Pressure				
High Cholesterol				
HIV/AIDS				
Kidney Disease				
Mental Disorders				
Sickle Cell Trait				
Stroke				

Medical History (the patient's past medical history)

☐ Acid Reflux/GERD	☐ Gallbladder Trouble	☐ Kidney Stones
☐ Anemia	☐ Glaucoma	☐ Liver Disease
☐ Asthma	☐ Gout	☐ Mental Health Disorders
☐ Bleeding Disorder	☐ Heart Attack(s)	☐ Panic Attacks
☐ History of Blood Transfusion(s)	☐ Heart Disease	☐ Poor Circulation (PAD/PVD)
☐ Cancer	☐ Hepatitis: A B C (please circle)	☐ Sickle Cell Anemia
☐ Chronic Bronchitis	☐ Hernia (abdominal)	☐ Sleeping Disorders
☐ Covid-19	☐ Hiatal Hernia	☐ Stroke(s)
☐ Diabetes	☐ High Blood Pressure	☐ Thyroid Problems
☐ Eating Disorder	☐ HIV/AIDS	☐ Tuberculosis
☐ Emphysema	☐ Kidney Failure	☐ Skin Ulcers/Lesions
☐ Epilepsy	☐ Kidney/Bladder Infections	☐ Stomach Ulcers

Additional Illnesses Not Listed Above: _____

_____

_____

☐ I have none of the problems listed above ☐ I have no current medical/health issues

F. Marion Dwight, MD, PA • Bamberg Family Practice

Patient Name: _____

Males:

Date of last colonoscopy _____ Date of last PSA _____

Females:

Date of last period _____ Date of last Pap _____

Date of last Mammogram _____ Date of last colonoscopy _____

List All Surgical procedures you have had in your life time & the year you had them:

- _____/_____
- _____/_____
- _____/_____
- _____/_____

Specialist (Does the patient see any specialty practitioners, i.e., Cardiologist, Nephrologist, Gastroenterologist, Endocrinologist, Rheumatologist, Chiropractors?):

Type of Specialist	Name of the Practice	Phone Number & City/Town

HIPAA Notice of Privacy Practices

F. MARION DWIGHT, MD, PA • BAMBERG FAMILY PRACTICE
2113 MAIN HWY. • PO BOX 120
BAMBERG, SC 29003 803-245-5168

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, clinical photography for diagnosis and treatment, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected health information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.
Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related service. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.
Payment: Your protected health information will be used, as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.
Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, naming of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.
We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.
Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.
You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.
You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.
You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations- You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
Your physician is not required to agree to a restriction that you may request, If physician believes it is in your best interest to permit use and disclose your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.
You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.
You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints.
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.
This notice was published and becomes effective on/or before April 14, 2003.
We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.
Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name _____ Signature _____ Date _____

F. Marion Dwight, MD, PA
Bamberg Family Practice
2113 Main Hwy., PO Box 120
Bamberg, SC 29003
803-245-5168 FAX: 803-245-6275

I authorize F. Marion Dwight, MD, PA to request my medication list from all participating pharmacies.

Patient Name _____ **Date of Birth** _____

Patient's Signature or Authorized Signature _____ **Date Signed** _____

LOCAL PHARMACIES

Place a check beside the pharmacies you use.
If not listed write in the name and city.

√	
	CVS (Denmark)
	CVS (Orangeburg-Calhoun)
	CVS (Orangeburg-Magnolia)
	CVS (Barnwell)
	Daniels (Barnwell)
	Daniels (Norway)
	Daniels (Denmark)
	Giant Pharmacy (Neeses)
	Grove Park
	Hiers Drug Store
	Wal-Greens (Bamberg)
	Wal-Greens (Calhoun)
	Wal-Greens (St Matthews Rd)
	WalMart (Barnwell)
	WalMart (Orangeburg)
	R & J Pharmacy (Norway)
	Express Scripts
	Optum Rx
	WalMart Neighborhood Pharmacy (Orangeburg)

Bamberg
FAMILY PRACTICE

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Today's Date: _____

I. AUTHORIZATION

I, _____, hereby voluntarily authorize the disclosure of information from my health record.

(Name of Patient) Patient DOB: _____

II. THE INFORMATION IS TO BE DISCLOSED BY:	III. AND IS TO BE PROVIDED TO:
NAME OF FACILITY	F. Marion Dwight, MD, PA Phone: (803) 245-5168
ADDRESS	2113 Main Highway Fax: (803) 245-6275
CITY/STATE	Bamberg, SC 29003

IV. THE PURPOSE OF THE AUTHORIZATION

☐ At my request ☐ Other: _____

V. THE INFORMATION TO BE DISCLOSED

☐ All of my health information

☐ My health information relating to the following treatment or conditions:

_____

☐ My health information covering the period of healthcare from:

_____ (start date to _____ (end date)

☐ Other: _____

VI. THIS AUTHORIZATION ENDS:

☐ On: _____ (date)

☐ When I am no longer a patient of F. Marion Dwight, MD, PA

☐ When the following event occurs: _____

I authorize the release of the records as indicated above and understand that the release may include sensitive information (mental and behavioral health, HIV/AIDS, communicable/infectious diseases, substance use disorder(s) and sexual assault.)

I understand that I have a right to cancel/revoke this authorization at any time. I understand that to do so I must put it in writing and present the written cancellation/revocation to the medical records department. I understand that the cancellation/revocation will not apply to information that has already been released. I understand that authorizing the disclosure of protected health information is voluntary. I have the right to refuse to sign this authorization. I do not need to sign this form to receive treatment. I understand that I may review and/or copy the information to be disclosed, as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the possibility of unauthorized disclosure by the person/organization receiving the information. I understand there may be fees for copies of medical records/images and postage fees may be charged as provided by S.C. Law. I understand that I will receive a copy of this authorization after I have signed it.

_____ _____

Signature of Patient or Legal Guardian/Representative Date

_____ _____

Relationship to Patient, if not signed by Patient Date of Birth of Patient

Payment Policy

1. Purpose

   At F. Marion Dwight, MD, PA aka Bamberg Family Practice, we are committed to providing excellent service and maintaining fair, transparent business practices. To support smooth operations and avoid billing delays, we require that **all payments be made in full at the time services are provided.**

2. Insurance Requirement
   - Patients are responsible for bringing copies of all insurance cards with them to their appointments.
   - The practice will verify insurance information at the time of appointment.
   - Bamberg Family Practice will bill the insurance company for the covered services provided.
   - It is the patient's responsibility to notify Bamberg Family Practice immediately of any changes in insurance.
   - Patients are not required to have insurance to be seen.

3. Payment Requirement
   - Payment of deductibles, copays, coinsurance, and noncovered services are due at the time of service.
   - Services will not be rendered without full payment except in extenuating circumstance which must be approved **at least 24 hours before the appointment.**

4. Accepted Payment Methods
   Bamberg Family Practice accepts the following forms of payment:
   - Cash
   - Credit or Debit Cards
   - Cash App
   - Check

5. Non-Payment
   - Patients who are unable or unwilling to pay at the time of service will be asked to reschedule.
   - Unpaid balances are subject to cancellation of future appointments until paid.

6. Questions
   If you have questions regarding this Payment Policy or need to request an exception, please contact the Financial Manager at (803) 245-5168, extension 117.

Thank you for your understanding and cooperation. This policy helps us keep our services accessible, efficient, and fairly priced for all customers.

NOTICE OF NONDISCRIMINATION

Discrimination is against the law.

F. Marion Dwight, MD, PA complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR 92.101(a)(2)). The clinic does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

F. Marion Dwight, MD, PA:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Business Office at (803) 245-5168, extension 117 or extension 120.

If you believe that F. Marion Dwight, MD, PA has failed to provide these services or discriminated in another way on the basis

of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Coordinator the following ways:

- In Person
- By mail to Civil Rights Coordinator, 2113 Main Hwy., Bamberg, SC 29003,
- By fax (803) 245-6275
- By email bfpmanager@bellsouth.net

If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D. C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at
https://www.hhs.gov/ocr/office/file/index.html

This notice is available at our website: Bambergfamily.com

Notice of Foreign Language Access

ATTENTION: If you speak _____, we have an arrangement for free translation services. Call 803-245-5168. (English)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 803-245-5168. (Spanish)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 803-245-5168. (Chinese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 803-245-5168. (Vietnamese)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 803-245-5168 (Korean)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 803-245-5168. (French)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 803-245-5168. (Tagalog)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 803-245-5168. (Russian)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 803-245-5168. (German)

ચુના: જો તમે જરાતી બોલતા હો, તો ન: લ્કુ ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છ. ફોન કરો 803-245-5168. (Gujarati)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة 8615-548-308 اللغوية تتوافر لك بالمجان. اتصل برقم (Arabic)

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 803-245-5168. (Portuguese)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。803-245-5168 (Japanese)

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 803-245-5168. (Ukrainian)

ध्यान द : य द आप हदी बोलते ह तो आपके लिए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 803-245-5168. (Hindi)

ប្រយ័ត ៖ េបើសិន អ កនិ យ ែខ រ, េស ជំនួយែផ ក េ យមិនគិតឈ ល គឺ ច នសំ ប់បំេរ អ ក។ ចូរ ទូរស័ព 803-245-5168. (Cambodian)