EAST ASHEVILLE FAMILY HEALTH CARE, PA

997 Old US Highway 70, Suite A

Black Mountain, NC 28711

(828)298-7981 Office (828)298-6010 Fax

James H. Early, M.D. **Anne J. Parker, FNP** **Thomas J. Wolf, M.D.** **Brenda C. Fore, FNP-BC**

Medical Registration Form

Last Name	First Name	Middle Name	Title	Other Name

Street Address	City	State	Zip Code	Home Phone	Cell Phone

Date of Birth	Age	Sex	Marital Status	Social Security Number	Email Address

Your Occupation	Your Employer	F/T – P/T Self Employed	Work Phone

Partner's Occupation	Partner's Employer	F/T – P/T Self Employed	Work Phone

Health Insurance Provider	Policy Number	Group Number	Co-Pay

Please provide a copy of your insurance card at the front desk when you arrive

Primary Insured Name	Primary Insured SSN	Primary's Date of Birth	Relationship to patient

Clinic Information

Previous Provider	Date of last physical exam	Reason for choosing this clinic

The above information is true to the best of my knowledge, I authorize my insurance benefits be paid directly to the medical provider. I understand that I am financially responsible for any balance. I also authorize East Asheville Family Health Center or insurance company to release information required to process my claims.

Patient/Guardian Signature	Date

Emergency Contact

Name	Relationship to Patient	Home Phone	Work Phone	Cell Phone

NOTICE: Medication list must be accurate. Please provide a list that includes **ALL** of your medications, If your medication list is error and fails to list a controlled substance that substance **WILL NOT** be prescribed by our practice.

Medical Information Sheet

Name	Date of Birth

Reason for today's appointment

USE SECOND SHEET FOR COMPLETE LIST IF NEEDED

Please list all the medicines (over the counter or prescriptions) that you currently take, along with the dosage and how often you take the medication.

What Pharmacy do you use: ____

Where is it located: ____

	No Medication Taken (not even over the counter like Tylenol, herbals or other meds bought from store)

Medication	Dose	When do you take this medication

Check any of your current or past medical problems:

	Anemia		Diabetes		Heart Disease		Stroke		COPD
	Arthritis		Blood Clots		Thyroid Disease		Seizures		High Blood Pressure
	Asthma		Kidney Disease		Cancer		Migraines		High Cholesterol
	Anxiety		Depression		Tuberculosis		Other		

Do you have any allergies? Please list the item and describe the reaction. No allergies check here ☐

Medication	Reaction

Environment	Reaction

Past Surgery Date

Patient Name | Date of Birth

Family Medical History

Relative	DoB	Age	Alive	Dead	Diabetes	Blood Pressure	Cancer	Stroke	Mental illness
Father									
Mother									
Father's Father									
Father's Mother									
Mother's Father									
Mother's Mother									
Sister 1									
Sister 2									
Sister 3									
Brother 1									
Brother 2									
Brother 3									

Do you drink alcohol? Yes / No If so, how much per week/per month? ___________________________

Do you use tobacco? Yes / No If so, what kind ________________ How much/often ____________ Years _______

Any other substance use? Yes / No If so, what _______________ how often _____________ years used ________

Coffee / Tea / Soft drinks – What ____________________________ how often ________________________

Do you exercise? Yes / No If so, what type ___________________________ how often ______________________

Give dates of immunizations/screening:

	Date		Date		Date
Influenza Vaccine		Pap Smear		Shingles Vaccine	
Pneumonia Vaccine		Colonoscopy		PSA	
Tetanus Vaccine		Mammogram		HPV	
Eye Exam					

EAST ASHEVILLE FAMILY HEALTH CARE, PA

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name | Address

Street/POB	
City	
State	
Zip	

I have received a copy of the Notice of Privacy Practices for the above-named practice.

Signature	Date

Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

An emergency existed & signature was not possible at the time	
The individual refused to sign	
A copy was mailed with a request for a signature by return mail	
Unable to communicate with the patient for the following reason:	
Other	
Prepared by	
Signature	
Date	

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to our successful treatment. Please undersant5 that payment of your bill is considered a part of your treatment. All patient must read, complete, sign and date our Patent Information for as well as our Financial Policy prior to any treatment. On all subsequent visits, we require all patient s to confirm our database information, and to provide the insurance card.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. In accordance with your contat wit your insurance provider. CO-PAYS are due at check-in for each office visit and the day prior to virtual/tele visits, in addition to any outstanding balances that may be on your account from previous visits. Your appointment will be rescheduled of you have an unpaid balance. WE ACCEPT CASH, CHECKS, MASTERCARD, OR VISA.

RETURNED CHECKS DUE TO NONSUFFICIENT FUNDS (NSF). Accounts with returned checks due to NSF may be assessed a minimum fee of $25, plus any bank charges levled against EAFHC due to NSF checks received from patients.

CASH PAYERS. 100% payment in full is due at the time services are rendered. We will not schedule future appointments if there is an unpaid balance on your account.

INSURANCE. Your are responsible for your (and your dependents) bill and your insurance coverage does not relieve you of this responsibility. This office may accept assignment of insurance benefits; however, you are required to pay all co-pays and deductibles at the tie of service. You must furnish our office with a copy of your current medical insurance card or we will not be able to file your insurance, Unless this office is participating provider, our insurance policy is contract between the insured and the insurance company, and this office is not bound by the contract, If your insurance company has not paid within 45 days, the full balance may be transferred to your responsibility and full and prompt payment will be expected.

OUT OF NETWORK INSURANCE. 100% payment in full is due at the time services are rendered After payment of your account balance, we will file your insurance as a courtesy, and your insurance company will reimburse you. We will not schedule future appointment if there is an unpaid balance on your account.

PRESCRIPTION. One business days' notice is required for prescription refills. All routine requests require that you call your pharmacy unless a written prescription is needed. To assist in keeping your prescriptions current, please bring all medications with you to your appointments.

There will be a $25 fee for non-routine prescriptions that are called in locally for acute problems that normally necessities an office visit. This fee will cover the time of taking symptoms over the phone, reviewing your medical record and medical decision making, An additional fee of $5 will be assessed for long distance prescription call-ins for all prescriptions (routine as well as non-routine). This charge will not be filed on your insurance. **NOTICE** Medication list must be accurate. Please provide a list that includes ALL of your medications. If your medication list is in error and falls to list a controlled substance that substance WILL NOT be prescribed by our practice.

TRANSFER OF MEDICAL RECORDS. There will be a charge for a personal copy or the permanent transfer of your records. Ciox has been contracted by our office to provide this service and will invoice you directly.

COMPLETION OF FORMS. There is a separate charge for a personal copy or the permanent transfer of your records. Ciox has been contracted by and time involved in completion. These charges are not covered by insurance and will be billed to your account.

CANCELLATION AND NO SHOW APPOINTMENT. Please notify the office at least 24 hours prior to your appointment time so that other patients can be worked into that time slot. A significant block of time is set aside for physical exam. If you cannot keep your appointment for a physical, we require a 48-hour advance notice of cancellation. There will be a $50 charge for physical appointments cancelled with less that 48-hour notice and "no-show" physical appointment. This charge cannot be filed with insurance. You will be responsible for this charge.

COLLECTION. In the event that you default on all or any portion of your financial obligation, your account may be turned over to a collection agency. At that time, charges will be added for attorney and collection fees incurred in the collection of said debt.

NOTICE OF FINANCE CHANGE. Effective May 1, 2010, and APR of 12% (1% monthly) will be assessed on the total unpaid account balance when any part of the balance is 30 days or more past due.

I HAVE READ, UNDERSTAND AND AGREE TO ABIDE BY THE POLICIES OF EAST ASHEVILLE FAMILY HEALTH CARE AS OUTLINED ABOVE.

Print Patient / Guardian name	Signature	Date

Witness Signature	Date

Authorization for Release of Information – Compound Release

Patient Name	Date of Birth

The above is authorized to release protected health information about the above-named patient in the following manner and to identified persons.

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	☐ Results of lab tests/x-rays ☐ Other(list)
☐ Other person (s)(provide name and number	☐ Financial ☐ Medical
☐ Email communication-provide email address* For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Appointment reminders ☐ Breach notification
☐ Text communication-provide number* *for text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other:

☐ For EMAIL and/or TEXT COMMUNICATION I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.

☐	Photo of patient received from patient or legal guardian
☐	Photo taken by staff (Example: pre/post procedure)
☐	Other Photo:
☐	May be posted in office
☐	May be posted on website
☐	Other use of photos:

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- 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 have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

Signature of Patient or Personal Representative	Date

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

Your Information. Your Rights. Our Responsibilities.

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.**

LAYERED SUMMARY TEXT –

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services

- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law

- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

- Insert Effective Date of this Notice
- Insert name or title of the privacy official (or other privacy contact) and his/her email address and phone number.
- Insert any special notes that apply to your entity's practices such as "we never market or sell personal information."
- The Privacy Rule requires you to describe any state or other laws that require greater limits on disclosures. For example, "We will never share any substance abuse treatment records without your written permission." Insert this type of information here. If no laws with greater limits apply to your entity, no information needs to be added.
- If your entity provides patients with access to their health information via the Blue Button protocol, you may want to insert a reference to it here.
- If your entity is part of an OHCA (organized health care arrangement) that has agreed to a joint notice, use this space to inform your patients of how you share information within the OHCA (such as for treatment, payment, and operations related to the OHCA). Also, describe the other entities covered by this notice and their service locations. For example, "This notice applies to Grace Community Hospitals and Emergency Services Incorporated which operate the emergency services within all Grace hospitals in the greater Dayton area."