

Internal Medicine Associates of Gastonia, Pa
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Patient Registration Form

Patient Information: (Please use full legal name, no nicknames)

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

Preferred phone # to be reached at: Home Cell Work Social Security #: _____

Date of Birth: _____ Sex: Male Female Marital Status: Single Married Divorced Widowed

Email Address: _____

Emergency Contact Name: _____ Emergency Phone #: _____

Insurance Information: (Please allow receptionist to photocopy your insurance ID cards)

Primary Insurance:

Plan Name: _____ Insured's Name: _____

Insured's Social Security #: _____ Insured's Date of Birth: _____

Policy / ID #: _____ Group #: _____ Effective Date: _____

Secondary Insurance:

Plan Name: _____ Insured's Name: _____

Insured's Social Security #: _____ Insured's Date of Birth: _____

Policy / ID #: _____ Group #: _____ Effective Date: _____

Patient's relationship to subscriber: (If other than patient, please list the following)

Subscribers Name: _____ Date of Birth: _____

Relationship to patient: Spouse Parent Other: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Internal Medicine Associates of Gastonia. I understand that all services may not be covered by my insurance plan and that I am financially responsible for any balances due. I authorize the doctor or insurance company to release any information required for payment of claims. A copy of this is as valid as the original.

Patient Signature: _____ Date: _____

Personal Health History

Patient Name: _____ **Date of Birth:** _____

Any allergies to medication or food (list reaction): _____

Preferred Pharmacy: _____

Date of last Complete Physical Exam: _____ Date of last blood work: _____

Routine Exams

Date of last Colonoscopy: _____ Date of last Mammogram: _____

Date of last Bone Density (DEXA): _____ Date of last Pap Smear: _____

Please list any surgeries you have had (include the month/year): _____

List all medications: _____

Social Information

Tobacco Use: Current Past Never Type: _____ # of Years: _____

Alcohol Use: Current Past Never Drinks/per week: _____

Drug Use: Current Past Never Type: _____

MEDICAL HISTORY

Please check all that apply

ADD/ADHD Alcoholism Allergies, seasonal Anemia Anxiety/Depression Arrhythmia (irregular heartbeat)

Arthritis Asthma Bipolar Bladder Incontinence Bleeding problems Cancer; type(s): _____

Crohn's Disease COPD Dementia Diabetes Type I or II Diverticulitis DVT (Blood clots)

GERD (Acid Reflux) Glaucoma Heart Disease Heart Attack Hiatal Hernia High Blood Pressure

High Cholesterol Headache HIV Hepatitis Irritable Bowel Syndrome Kidney Stones

Kidney Disease Lupus Liver Disease Macular Degeneration Neuropathy Osteopenia/Osteoporosis

Parkinson's Disease Peripheral Vascular Disease Peptic Ulcer Psoriasis Pulmonary Embolism

Rheumatoid Arthritis Seizure Disorder Sleep Apnea Stroke Thyroid Disorder Ulcerative Colitis

Other: _____

Consent for Medical Treatment

- Consent for medical treatment: I am asking for care, and I agree to be given and/or referred for necessary diagnostic tests, examinations, and medical treatments prescribed by the physician treating me at Internal Medicine Associates of Gastonia, PA. No one has given me a guarantee about how these examinations and treatments will affect me or my condition.
- Medicare Certification: I have given the correct information for payment under Titles XVII (Medicare) of the social security act. I ask that any authorized Medicare benefits be paid on my behalf, for services furnished to me by Internal Medicine Associates of Gastonia, PA.
- Personal Valuables: Internal Medicine Associates of Gastonia, PA takes precautions to protect my property, but they do not accept responsibility for the loss or damage of any personal property I bring into the office.
- Acknowledgment of receipt of notice of privacy practices: I have been offered a copy of the notice of privacy practices for Internal Medicine Associates of Gastonia, PA.
- E-Prescribing Consent: E-Prescribing is defined as a physician’s ability to electronically send an accurate, error free and understandable prescription directly to the pharmacy from the medical office. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. This greatly reduced medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an E-Prescribe program. Medication history transactions provides the physician with information about medications the patient has already taken and minimizes the number of adverse drug events. Fill status notification allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient’s prescription has been picked up, not picked up, or partially filled. By signing below, you are agreeing that Internal Medicine Associates of Gastonia, PA can request and use your prescription and medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes. Understanding all the above, I hereby provide informed consent to Internal Medicine Associates of Gastonia, PA to allow these E-Prescribing functions. I have had the chance to ask questions and all my questions have been answered to my satisfaction.
- Complete Physical Exams: I acknowledge that if there is any abnormality found or mentioned during my complete physical exam, the visit will then become a “problem visit” and will not be filed as a well check.

I certify that I have been made aware of Internal Medicine Associates of Gastonia, PA **Notice of Privacy Practices** and that I have a right to receive a copy upon request. This Notice describes the type of uses and discloses of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of Internal Medicine Associates of Gastonia, PA duties with respect to my protected health information. I understand that copies of the **Notice of Privacy Practices** are available at the request of our front desk staff. Internal Medicine Associates of Gastonia, PA reserves the right to change the privacy practices that are described in the **Notice of Privacy Practices** by asking for one at the time of my next appointment.

Patient Name: _____

Patient Signature: _____

Date: _____

Financial Policy

This financial policy contains information about billing and payment options for professional services rendered to our patients. This policy outlines the responsibilities of the patient and our practice. Please read the policy in its entirety.

- Payments for professional services can be made by cash, check or credit card. We accept Visa, Discover, Mastercard and American Express. It is your responsibility to make payments at the time of service for any co-payment, co-insurance or deductible amounts that are due. Any service not covered by your insurance plan are your responsibility and payment is expected at the time services are rendered. WE do not extend credit.
- Our practice participates with most health insurance companies, managed care programs and Medicare. Our office will submit a claim for services rendered to you. It is the responsibility of the patient to provide the most current and correct insurance information.
- Claims denied due to outdated or incorrect insurance information will become the responsibility of the patient and will be expected to pay the balance in full for any services provided to you that day.
- If you are a member of an insurance plan with which we do not participate, we will file the claim on your behalf, but you will be responsible to pay in full for any services provided to you that day.
- Insurance plans rarely cover all services or pay the entire amount of those that are covered, and it is the responsibility of the patient to understand any benefit limitations and restrictions of your particular insurance plan. You may be asked to sign a waiver prior to receiving services if we anticipate any services provided may not be covered by your insurance plan.
- Our office does not accept Medicaid.

Medicare Patient: Internal Medicine Associates of Gastonia, PA participates with Medicare; however, Medicare only pays a portion of your bill. If you do not have a secondary or supplemental insurance coverage you will be required to pay 20% of Medicare's allowable charge along with any remaining portion of your annual deductible at the time of service. Payment for services not covered by Medicare are to be paid in full on the date the service is rendered.

Returned Check Policy: In the event of a returned check your account will be charged the current fee charged by the bank for processing of returned checks and you must pay in cash, certified funds, or credit card. We will no longer be able to accept check for any future payments at this office.

Overdue Balances: All overdue balances will be sent to a collection agency. The patient will receive four statements prior to being sent to collections. All accounts sent to collections will be a \$50 fee in addition to the prior balance.

Cancellations, Late Arrivals, & No-Shows: If you cannot keep your appointment, please call to cancel, so that we may use that available time for another patient. Please understand that when you do not cancel an appointment, it prevents other patients from receiving care they need. A \$50 fee will be charged to your account for appointments not cancelled within 24 hours. We offer a 20-minute grace time window for anyone who may be late for your appointment. If you are going to be late, please call to let the front desk know that you are intending to keep your scheduled appointment. A patient that fails to keep three or more appointments without prior notice of cancellation or habitual cancellation of appointments will be subject to discharge from the practice.

By signing below, I certify I have read and understand the foregoing, have had the opportunity to ask questions and have them answered and accept the above conditions and terms and I agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductibles, co-payments, and non-covered. I also agree in the event my account must be placed with a collection account to obtain payment, I will pay the collection costs incurred by Internal Medicine Associates of Gastonia, PA.

Patient Name: _____

Patient Signature: _____

Prescription & Narcotic/Opioid Agreement

The physicians may/may not prescribe you narcotics/opioids for the treatment of pain and their decision is based upon your condition and their examination. I understand that the uses of narcotics/opiates have associated risks, including but not limited to: drowsiness, constipation, nausea, itching, dizziness, and slowed breathing. Physical dependences, tolerance to analgesics, and the possibility that the medication may no longer provide complete pain relief. If prescribed pain medication and should the medication cause drowsiness or slowed reaction time or reflexes, I will not be involved in any activity that may be dangerous to me or anyone else. I understand that addiction is defined as the use of a medication even if it causes harm, feeling the need to use a drug and decrease quality of life. Addiction is characterized by inability to consistently abstain, impairment in behavior control, and craving, diminished recognition of significant problems with one's behavior and interpersonal relationships, and a dysfunction emotional response. I understand that the chance of becoming addicted to pain medication is very low when the medication is taken prescribed by the physician. I understand that the development of addictions is more common in a person who has a family/personal history of addiction. I agree to inform my physician honestly of any personal drug history and any family history to the best of my knowledge.

- I will not seek any prescriptions for narcotics/opiates from any other physician without prior approval from Internal Medicine Associates of Gastonia.
- I will tell the doctor about all medications and treatments that I am current on or previously had.
- I will comply with all follow-up appointments for monitoring my condition and medications.
- I will comply with any request to have a urine or blood test to determine if I am taking my medications properly.
- I understand that if I am caught selling or abusing the medication for purposes other than prescribed or arrested for any illegal drug charges, I will be discharged from the practice.
- I understand if I test positive for marijuana, PCP, or cocaine I may be discharged from the practice.
- I will designate one pharmacy where all my prescriptions are filled.
- I will participate in a program for chemical dependency should a problem be identified.
- If I am a female, I will inform my doctor if I should become pregnant or plan to become pregnant.
- I understand that no medications will be changed over the telephone and that no early refills will be given for any medications. It is my responsibility to take my medications as prescribed.
- I understand that if my medications/prescriptions are lost, stolen, or misplaced they will not be replaced regardless of the circumstances. It is my responsibility to keep them in a safe and secure location out of reach of children and others.
- I understand that all unpaid balances must be paid in full before any controlled substances can be refilled.
- I understand that any violation of this agreement will result in narcotics/opiates being discontinued and I will be discharged from the practice.
- I understand that continually calling regarding prescriptions is considered harassment and will result in narcotics/opiates being discontinued and I will be discharged from the practice. Please allow 24 hours for prescriptions to be refilled.
- No refills will be given nights, weekends, or holidays.
- I understand that the narcotic/opiate that has been prescribed to me, should show up in my urine drug screen, if it does not, the prescription is not being taken as prescribed and therefore I will be discharged from the practice.

I have not been dismissed from a pain center or doctor's office due to abuse of their policies.

I have been dismissed from a pain center or doctor's office due to abuse of their policies.

I have read this agreement or had it read to me and understand the terms and conditions associated with them. I was given the opportunity to ask questions and have them answered to my satisfaction. I understand that by not following the policies above, I will be discharged from this practice. I also understand that any dishonesty on my part breaks the physician-patient trust and will result in discharge from the practice. By signing this form I agree to follow all rules and policies above and understand that I can receive a copy at my request.

Patient Name: _____

Patient Signature: _____

Medical Information Release Form

Internal Medicine Associates of Gastonia, PA & Harmony Medical Spa, to comply with the HIPAA Privacy Regulation, requires an authorization from the patient before detailed messages are left for the patient. This policy is to protect the privacy of the patient and to protect the physicians and staff of Internal Medicine Associates of Gastonia, PA & Harmony Medical Spa violating the patient's confidentiality. If there is not a signed consent on file physicians and staff will only leave their name and telephone number on an answering machine, voicemail, or with a live person answering the phone requesting the patient to return the call.

Name: _____ Date of Birth: ____/____/____

Release of Information

I authorize the release of information including the diagnosis, records, examination results, medication dose changes, and claims information.

This information may be released to:

Information is not to be released to anyone other than me.

Spouse: _____ Phone No.: _____

Child(ren): _____ Phone No.: _____

Other: _____ Phone No.: _____

Other: _____ Phone No.: _____

Messages

Please call my home phone# _____ my cell phone# _____

If unable to reach me:

Do not leave messages on my phone mailbox

You may leave a detailed message

OR

Please leave a message asking me to return your call

This Release of Information will remain in effect until terminated by me in writing. This release **specifically excludes** any psychiatry and psychology evaluations/records which are further restricted by HIPAA regulations.

Patient signature

Date

Medical Office Staff Signature

HIPAA- Notice of Privacy Practice Acknowledgment

_____ I have been provided a copy of Internal Medicine Associates of Gastonia & Harmony Medical Spa Notice of Privacy Practice.

_____ I declined a copy of Internal Medicine Associates of Gastonia & Harmony Medical Spa Notice of Privacy Practice.

Patient Signature