Internal Medicine Associates of Gastonia, PA
2391 Court Drive , STE 110 Gastonia, NC 28054
Jaime Villarreal,MD Kelly Shedd, MD

WELCOME

PLEASE SEE THE ATTACHED PAPERWORK TO BE COMPLETED

PRIOR TO YOUR APPOINTMENT DATE & TIME.

PLEASE BRING YOUR DRIVERS LICENSE, INSURANCE CARDS, COPAY AND

LIST OF CURRENT MEDICATIONS WITH YOU TO

YOUR NEW PATIENT APPOINTMENT.

Please arrive 15 minutes prior to your appointment.

PLEASE ***DO NOT SIGN*** YOUR NEW PATIENT PAPERWORK

UNTIL YOU ARRIVE TO ***YOUR APPOINTMENT***.

Thank you for choosing Internal Medicine Associate of Gastonia.

Updated June 16th, 2016

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PATIENT INFORMATION **MRN** _____

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ ☐ Home ☐ Cellphone ☐ Work phone

Secondary Phone: _____ ☐ Home ☐ Cellphone ☐ Work phone

Email: _____

Date of Birth: _____ Social Security Number: _____

Gender: Male ☐ Female ☐ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Emergency Contact _____ Phone _____

INSURANCE INFORMATION

Primary Insurance

Insurance Company: _____

Name of Insured: _____

Date of Birth: _____ Relationship to Patient: _____

Employer: _____

Secondary Insurance

Name of Insured: _____

Date of Birth: _____ Relationship to Patient: _____

Employer: _____

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 RESONSIBLE 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

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1. 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 ASSOC OF GASTONIA, PA. NO ONE HAS GIVEN ME A GUARANTEE ABOUT HOW THESE EXAMINATIONS AND TREATMENTS WILL AFFECT ME OR MY CONDITION.
2. MEDICARE CERTIFICATION: I HAVE GIVEN 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 ASSOC OF GASTONIA, PA.
3. PERSONAL VALUABLES: INTERNAL MEDICINE ASSOC OF GASTONIA 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.
4. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I HAVE BEEN OFFERED A COPY OF THE NOTICE OF PRIVACY PRACTICES FOR INTERNAL MEDICINE ASSOC OF GASTONIA, PA.

E-PRESCRIBING CONSENT: E-PRESCRIBING IS DEFINED AS A PHYCISICAN'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 REDUCES MEDICATION ERRORS AND ENHANCES PATIENT SAFTEY. 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 IS ALREADY TAKING 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* CAN REQUEST AND USE YOUR PRESCRIPTION MEDICATION HISTORY FROM OTHER HEALTHCARE PROVIDERS AND/OR THIRD PARTY PHARMACY BENEFIT PAYERS FOR TREATMENT PURPOSES. UNDERSTANDING ALL OF THE ABOVE, I HEREBY PROVIDE INFORMED CONSENT TO *INTERNAL MEDICINE ASSOCIATES OF GASTONIA* TO ALLOW THESE E-PRESCRIBING FUNCTIONS. I HAVE HAD THE CHANCE TO ASK QUESTIONS AND ALL OF MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION.

I HAVE READ, UNDERSTAND, AND AGREE TO THE TERMS AND CONDITIONS OF THE ABOVE INFORMATION. A COPY OF THIS IS AS VALID AS THE ORIGINAL.

Patient Name (print) Date

Patient Signature Date

Witness Signature Date

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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-payments, co-insurance or deductible amounts that are due. Any services not covered by your insurance plan are your responsibility and payment is expected at 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 not paid by your insurance company.
- 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 same day as your visit.
- 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 Patients

Internal Medicine Associates of Gastonia, PA participates with Medicare; however, Medicare only pays a portion of your bill. If you do not have 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 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 by cash, certified funds or credit card. We will no longer be able to accept checks for any future payments at this office.

CANCELLATIONS, LATE ARRIVALS AND NO-SHOW POLICY

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 $30 fee will be charged to your account for appointments not cancelled within 24 hours.** If you are going to be late for your appointment, please call ahead and ask if it is possible to still be seen or reschedule your appointment for possibly later time that day. **We cannot guarantee you can be seen or will be able to reschedule your appointment for the same day. 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.**

I acknowledge that Internal Medicine Associates of Gastonia, PA has made available to me the financial policy. I have read the policy or it has been read to me and I understand the terms and conditions associated with this policy. By signing this form I agree to my responsibilities as outlined above and can be given a copy if I wish to have one for my records.

_____

Patient Name (print) Date

_____

Patient Signature Date

_____

Witness Signature Date

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Prescription and Narcotic/Opioid Agreement

The physicians may/may not prescribe you narcotic/opiates 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 dependence, 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 decreased quality of life. Addiction is characterized by inability to consistently abstain, impairment in behavioral control, and craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. I understand that the chance of becoming addicted to pain medication is very low when the medication is taken as 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 PHYSICIANS.
- I WILL TELL THE DOCTOR ABOUT ALL MEDICATIONS AND TREATMENTS I AM CURRENTLY 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 MEDICATIONS 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 WILL BE DISCHARGED FROM THE PRACTICE.**
- I WILL DESIGNATE ONE PHARMACY WHERE ALL MY PRESCRIPTIONS ARE FILLED.
- I WILL PARTICIPATE IN A PROGRAM FOR CHEMICAL DEPENDCY SHOULD A PROBLEM BE IDENTIFIED.
- IF I AM A FEMALE, I WILL INFORM THE 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/PRESCRIPTION IS LOST, STOLEN OR MISPLACED, ETC. 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 HARRASSMENT 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 OFFICE POLICIES.

☐ **I HAVE BEEN** DISMISSED FROM A PAIN CENTER OR DOCTOR'S OFFICE DUE TO ABUSE OF THEIR OFFICE 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 dishonestly 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 I understand that I can receive a copy at my request.

Patient Name (print)	**Date**
Patient Signature	**Date**
Medical Office Witness	**Date**

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Authorization to Release Healthcare Information

Patient Information (PLEASE PRINT):

Name Date of Birth

☐ I do not authorize any healthcare information to be disclosed to anyone other than myself.
☐ I authorize any healthcare information to be disclosed to myself and individuals listed below

By authorizing the individuals listed below Internal Medicine Associates of Gastonia, PA may communicate with them information including, but not limited to, prescription refills and/or samples, reasons for particular visits, billing/insurance information, appointment times, lab and test results, etc.

Name Relationship

Name Relationship

Name Relationship

Right(s) of Patient

I understand that I have the right to revoke and/or change this authorization at any time. I understand that revocation is not effective in cases where the information has already been disclosed and that information disclosed may be subject to re-disclosure by the recipient. This information may no longer be protected by state or federal laws.

Patient Signature Date

Medical Office Witness Date