Internal Medicine Associates of Gastonia, PA

Dr. Jaime Villarreal, M.D.

Dr. Kelly Shedd, M.D.

Harold Fite, PA

PATIENT INFORMATION

Last Name: ______________________________ First Name: ________________________ MI: _______________

Date of birth: _________________________ Social Security #: _______________________ Sex: ☐ Male ☐ Female

Address: ________________________________ City: ____________________ State: __________ Zip: _________

Home Phone #: _______________________ Cell Phone #: __________________ Work Phone #: _______________

Preferred phone # to be reached at: ☐ Home ☐ Cell ☐ Work

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Email Address: ____

Emergency Contact: ________________________________ Emergency phone #: ____________________________

INSURANCE INFORMATION

Please allow the receptionist to photocopy your Insurance ID cards.

Primary Insurance

Plan name: ___________________________________ Insured's Name: ___________________________________

Insured's SS#: _____________________________________ Insured's DOB: _______________________________

Policy / ID #: ____________________________________ Group #: __________________ Effective date: _________

Secondary Insurance

Plan name: __________________________________ Insured's Name: ___________________________________

Insured's SS#: _____________________________________ Insured's DOB: _______________________________

Policy / ID #: ____________________________________ Group #: __________________ Effective date: _________

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

Subscriber's 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, PA. I understand that all services may not be covered by my insurance 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.

Signature: ____ Date: __________________________________

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PERSONAL HISTORY

Patient name: ____ Date of birth: ______________________

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

____

Preferred Pharmacy (Local and/or Mail Order): ____

____

ROUTINE EXAMS

Date of last Colonoscopy: ____________________________ Date of last Mammogram: ____________________

Date of last Bone Density (DEXA Scan): ____________________ Date of last Pap Smear: ____________________

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

☐ ADD/ADHD ☐ Alcoholism ☐ Allergies (seasonal) ☐ Anemia ☐ Anxiety/Depression

☐ Arrhythmia ☐ 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 ☐ Glaucoma ☐ Heart disease ☐ Heart Attack ☐ Hiatal Hernia

☐ High blood pressure ☐ High Cholesterol ☐ Headache ☐ HIV ☐ Hepatitis

☐ Irritable Bowel Syndrome ☐ Kidney Stones ☐ 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: ____

MEDICATIONS

Please list medication name, dosage, and quantity

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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 must be included in an E-Prescribe program. Mediation 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 agree 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.

Print name: ________________________________ Signature: _____________________ Date: __________________

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PRESCRIPTION & NARCOTIC/OPIOD 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 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 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 the medications are 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.

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I have read this agreement or had it read to me and understand the terms and conditions assocaited with them. I was given the opportunity to ask questions and have them ansered to my satisfaction. I undersand that by not following the polocies above, I will be dishcarged from this practice. I also understand that any dishonesty on my part breaks the physcian-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.

Print name: ________________________________ Signature: _____________________ Date: __________________

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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.

Patient Name: ____ Date of birth: ________/________/________

Release of Information:

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

This information may be released to:

Name: ______________________________ Relationship: _______________ Phone #: _____________________

Name: ______________________________ Relationship: _______________ Phone #: _____________________

Name: ______________________________ Relationship: _______________ Phone #: _____________________

Name: ______________________________ Relationship: _______________ Phone #: _____________________

☐ Information is not to be release to anyone other than myself.

Messages:

Please contact me at: ☐ Cell Phone ☐ Home Phone ☐ Work Phone

If unable to reach me: ☐ Do not leave messages on my phone mailbox. ☐ May leave a detailed message.

☐ Leave a message asking for a return 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.