Primary Medical Care at the Crossroads

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58 Old Roberts Road • Suite 102 • Benson, NC 27504

Phone: 919.934.2600 • Fax: 1.833.989.2097

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

Date of Birth: _____ Social Security #: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Primary Phone #: _____ (circle one) Home/Cell/Work

Email Address: _____

Gender: ___ Male ___Female

Race: *(Circle one):* American Indian/Alaska Native Asian Black/African American Native Hawaiian Pacific Islander White More than one race Do not wish to report

Ethnicity: *(Circle one)* Non-Hispanic/Latino Hispanic/Latino Do not wish to report

Martial Status: *(Circle one)* Single Married Divorced Widowed

Preferred Language: English Spanish Other: _____

Emergency Contact: *(Name, Relationship, & Phone #)*

_____

Primary Care Physician: *(Name & Phone #)*

_____

Primary Insurance Name: _____

Secondary Insurance Name: _____

Preferred Pharmacy: *(Name, Address, Phone #)* _____

_____

Occupation and Employer: *(Name and Phone #)* _____

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Consent for Treatment

I hereby authorize the release of medical information related to the services rendered. I attest the insurance information is correct and I authorize payment of medical benefits directly to the physician.

Signature: _____

I have been informed of the availability of chronic care management services. I consent to electronic communication of medical information with other treating practitioners and providers.

Signature: _____

Financial Consent

I understand that payment for services provided by *Primary Medical Care at the Crossroads, PLLC* will be my responsibility. My insurance carrier will be billed for these services as a courtesy and my uncovered charges, deductibles, or co-pays will be my responsibility. I hereby assign all medical benefits, if any, payable directly to this medical practice. I authorize the release of all information necessary to secure payment of benefits. I authorize *Primary Medical Care at the Crossroads, PLLC* to submit claims to my insurance carrier in order to obtain payment for professional services rendered.

By signing below, I understand and agree that in the event of default, I am legally liable for all costs of collections including collection fees, court costs, and all other costs related to the collection of this debt.

Signature: _____ Date: _____

Primary Medical Care at the Crossroads

HIPPA (Health Insurance Portability & Accountability Act of 1995) is a federal regulation requiring that we provide you with a detailed notice in writing of our privacy practices. This notice is available to all patients who ask to read it.

I understand that under HIPPA, I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to:

- Conduct, plan, and direct treatment and follow-up among the multiple health providers who may be involved in my treatment, both directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations, such as quality assessments and provider certifications.

I acknowledge that I have been given the opportunity, prior to signing this consent, to read Primary Medical Care at the Crossroads Notice of Privacy Practice, which contained a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it's Notice of Privacy Practice from time to time and that I may contact this organization at any time to obtain a current copy of the notice of Privacy Practices.

I acknowledge that I may request in writing that you restrict how my private information is used and disclosed to carry out treatment and/or payment of healthcare operations. I also understand that you are not required to agree to my requested restriction(s), but if you agree then you are bound to abide by such restrictions.

I acknowledge that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Authorizations

Please check the specific information you wish to be used or disclosed:

___Any Medical Information

___Medical Information

___Test Results

___Procedure Information

___Lab Work

___Office Visits

The following individuals are authorized to make a request for the information above:

Name: Relationship:

_____ _____

_____ _____

___DO NOT release any medical information to anyone.

Patient Signature: _____ Date: _____

Primary Medical Care at the Crossroads

Permission to Photograph

I agree that Primary Medical Care at the Crossroads may take a digital photo of me for my Athena Medical Record at PMC. I understand the following:

- The photo will be stored permanently in my medical record.
- The photo will be used to identify me when I come to this office for care.
- The photo will be stored securely to protect my privacy.
- The photo will NOT be used outside of PMC. unless I (or my legal representative) give permission in writing.
- PMC will own the photo. I can look at the photo.

_____

Patient Signature (or authorized representative)

_____ _____

Relationship to Patient Date

I decline to have my photo taken:

_____ _____

Patient Signature (or authorized representative) Date

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NO SHOW/CANCELLATION POLICY

We understand that you may need to cancel or reschedule your appointment and that emergencies do occur. If you are unable to keep your appointment, please call us as soon as possible. Our cancellation policy is at least a 24-hour notice. This allows for other patients to be seen in a timely manner. Please call our office telephone number at 919.934.2600 to cancel and/or reschedule an appointment.

As a courtesy, a reminder call is made one day prior to your scheduled appointment. However, it is the responsibility of the patient to arrive to their scheduled appointment on time or notify the office.

After the first missed appointment, the patient will receive a "NO SHOW" phone call. After the second missed appointment, a "NO SHOW" fee of $25 will be billed to the patient. This fee is the responsibility of the patient and not covered by insurance. After the third missed appointment, dismissal from the practice will be considered.

Thank you for understanding and cooperating as we strive to best serve the needs of all our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

Printed Name: _____ Date: _____

Signature: _____

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Medication Refill Policy

1. It is your responsibility to notify the office in a timely manner when refills are necessary. Approval of your refill may take up to two (2) business days. Please be courteous.

2. If you use a mail order pharmacy, please contact us seven (7) business days before your medication is due to run out.

3. Medication refills will only be addressed during regular office hours: Monday-Thursday 8am-5pm.

4. NO prescriptions will be refilled on Saturday/Sunday or Holidays.

5. Refills can only be authorized on medication prescribed by our providers from our office.

6. We will NOT refill medications prescribed by other providers.

7. Some medications require prior Authorization. Depending on your insurance, this process may involve several steps by both your pharmacy and the provider. The providers and pharmacies are familiar with this process and will handle the prior authorization as quickly as possible. Neither the pharmacy nor the provider can guarantee that your insurance company will approve the medication. Please check with your pharmacy and insurance company for updates.

8. It is important that you keep your scheduled appointment to ensure that medication refills are not delayed or missed. Repeated no-shows or cancellations will result in a denial of refills.

9. If you have any questions about your medications, please address them during your office visit. If for any reason you feel your medication needs to be adjusted or changed, please contact our office immediately.

10. New symptoms or events require an examination by the provider. We will NOT diagnose or treat over the phone.

Patient Signature: _____ Date: ____/____/_____

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Controlled Substance Medications Agreement

I understand and voluntarily agree that:

1. I will keep (and be on time for) all my scheduled appointments with the provider.
2. I will keep the medication safe, secure, and out of the reach of children. If the medicine is lost or stolen, I understand it will not be replaced until my next appointment and may not be replaced.
3. I will take my medication as instructed and not change the way I take it without first talking to the provider.
4. I will not call between appointments to request refills. I understand that prescriptions will be filled only during scheduled office visits.
5. I will make sure I have an appointment for medication refills. If I have a difficult time scheduling an appointment, I will notify a member of the treatment team immediately.
6. I understand that prescriptions will be e-prescribed to my pharmacy.
7. I will treat the office staff respectfully at all times. I understand that if I am disrespectful to staff, disrupt the care of other patients, my treatment will be discontinued, and I will be immediately released from the practice.
8. I will not sell this medication or share it with others. I understand that if I do, my treatment will be discontinued.
9. I will sign a release form to let the provider speak to all other providers that I see. I will tell the provider all other medications that I take and notify them immediately if I have a prescription for a new medication.
10. I understand and will NOT get any opioid pain medications or other medications that can be addictive such as benzodiazepines (klonopin, Xanax, valium) or stimulates (Ritalin, amphetamine) without telling the provider before I fill the prescription.
11. I will not use illegal drugs such as heroin, cocaine, marijuana, or amphetamines. I understand that if I do, my treatment will be discontinued.
12. I will come in for drug testing and counting of my pills on the day I am notified. I understand that I must make sure the office has my most current contact information in order to contact me. Any missed tests will be considered positive for drugs.
13. I understand that I may lose my right to treatment in this office if I break any part of this agreement.
14. I will use only ONE pharmacy to get all of my prescription medications.

Pharmacy name and Phone number: _____

Printed Name: _____

Signature: _____ Date: _____

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Personal Medical History

Please check all that apply:

____ ADHD
____ Alcohol Abuse
____ Anxiety
____ Arthritis
____ Asthma
____ Cancer/Type ____
____ Constipation
____ Thyroid Disorder
____ Depression
____ Diabetes/Type: I/II
____ High Cholesterol
____ Glaucoma
____ Heart Attack
____ Heart Disease
____ Diarrhea
____ COPD
____ High Blood Pressure
____ Kidney Disease
____ Migraines
____ Obesity
____ Stroke
____ Substance Abuse
____ Heartburn/Reflux
____ Other_____

Please list any hospitalizations or surgeries:

Reason for Hospitalization or Type of Surgery	Date

Family History:

Please check all that apply

	Paternal Grandparents	Maternal Grandparents	Father	Mother	Siblings	Children
Alcoholism						
Anxiety						
Breast Cancer						
Colon Cancer						
Lung Cancer						
Prostate Cancer						
Skin Cancer						
COPD						
Depression/Mental illness						
Diabetes						
Heart Disease						
Hypertension						
Stroke						

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Social History

Tobacco Use: _____ Daily _____ Some days _____ Former _____ Never

Packs per day: _____ Per week: _____

If a former smoker, please indicate: Date quite smoking: _____ OR # of years smoked: _____

Do you vape? _____ Yes _____ No

Alcohol Use: _____ Yes _____ No

Drinks per day: _____ Per week: _____

What type of alcohol:

Illicit Drug Use: _____ Yes _____ No

Please select all that apply: ___Marijuana ___Cocaine ___Heroin Other: _____

Occupation: _____

_____ Student _____ Unemployed _____ Retired _____ Disabled

Do you wear a seatbelt at all times? _____ Yes ____ Occasionally _____ No

Do you consume an excessive amount of processed meat? _____Yes _____ No

Preventative Care

List if you have had the following:

	Date:		Date:
Tetanus Vaccine	_____	Prostate Cancer test	_____
Pneumonia Vaccine	_____	Eye Exam	_____
Flu Vaccine	_____	Diabetic Foot Exam	_____
Hepatitis B Vaccine	_____	Colonoscopy	_____
Shingles Vaccine	_____		
Mammogram	_____		
PAP Smear	_____		

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Medication List

In an effort to provide the best quality patient care, PMC need a complete list of ALL of your medications (including over-the-counter, herbal, vitamins, supplements, etc).

It is pertinent that you bring **ALL** of your medications to each appointment for verification, to assess compliance, and determine if refills are needed.

Medication	Dosage	Frequency

ALLERGIES:

Medication or Food Name	Specific Reaction (*Difficulty breathing, Throat swelling, rash, nausea/vomiting, etc*)