MEDICAL ARTS FAMILY PRACTICE, P.A.

MISSION STATEMENT

It is the mission of Medical Arts Family Practice, P.A. to provide quality healthcare in the most professional, compassionate, and cost effective manner possible. It is our continuing goal:

- to treat the whole individual, not just the disease.
- to maintain costs while never compromising the quality of care.
- that continuing education is a journey, not a destination, provided for our patients and staff.
- to remain on the cutting edge of new technology and programs to enhance the quality of care for our patients.

Medical Arts Family Practice
413 Owen Dr
Suite 201
Fayetteville, NC 28304
Phone: 910-323-9111

_____,

Welcome to our practice! For your upcoming appointment on _____ with _____, we ask that you arrive by _____, with the following items:

- Photo ID (Driver's License)
- Insurance Card
- Any medications you are currently taking (in their original bottles)
- The attached forms completed
- Copays and deductibles are due at the time of service
- This is a new patient visit to get established with our practice. This visit is not a physical.

We look forward to meeting you! Please feel free to contact our office with any questions or concerns you may have prior to your visit.

Medical Arts Family Practice

New Patient Registration Record

Please Print

NAME LAST	FIRST	MIDDLE	GENDER ID

HOME ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE ( )	CELL PHONE ( )	BIRTHDATE	SOCIAL SECURITY

EMAIL ADDRESS	SINGLE MARRIED DIVORCED WIDOWED
EMPLOYER NAME	**EMPLOYER ADDRESS / PHONE NUMBER** ( )
INSURANCE #1	POLICY #
INSURANCE #2	POLICY #
SPOUSE'S NAME	WORK PHONE ( )
RELATIVE **NOT** LIVING WITH YOU	PHONE ( )
FRIEND **NOT** LIVING WITH YOU	PHONE ( )
LANDLORD	PHONE ( )
WHOM MAY WE CONTACT IN CASE OF EMERGENCY?	PHONE ( )
WHOM MAY WE THANK FOR REFERRING YOU?	PHONE ( )
WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL?	

I will be paying today by ☐ Cash ☐ Check ☐ Credit Card

I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

ASSIGNMENT OF BENEFITS/AUTHORIZATION FOR TREATMENT: I hereby authorize treatment and authorize the provider of medical services to release information for these services to my insurance carrier for payment. I further authorize that payment of benefits be made to the provider on my behalf, or to myself. I understand that I am financially responsible for all charges not covered by my insurance.

_____ _____

SIGNATURE DATE

_____ _____

PARENT (IF MINOR) DATE

About Financial Arrangements and Medical Insurance

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, MasterCard, or Visa. We will be happy to help you process your insurance claim form for your reimbursement. Any such request must be accompanied by a **completed** insurance form at each visit. In **special** instances we may accept assignment of insurance benefits.

Returned checks and balances older than 30 days may be subject to additional collection fees. **Charges will apply for appointments not cancelled 24 hours in advance. Office Visit - $25.00, Physical/Procedure - $50.00. _____ Initials**

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowable determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of "U.C.R.". "UCR" is defined as usual, customary and reasonable fees for this region. Thus, our fees are considered UCR by most companies. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears to relationship to the current standard and cost of care in this area.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payments of your account. If such problems do arise we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, **PLEASE** don't hesitate to ask us. We are here to help you.

PLEASE COMPLETE THE REGISTRATION ON OTHER SIDE ☞

MEDICAL ARTS FAMILY PRACTICE

CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION TO FAMILY

You or your legally authorized representative may have a copy of your medical/financial records. In many instances, we will not be able to give you a copy of your medical recored immediately. We will process your request as promptly as possible and we reserve the right to charge you our normal reproduction of $0.10 per page for medical requests.

Patient Name _____ Chart # _____

I consent to disclosure of the following protected health information about me to the following family member(s) or person(s) involved in my care or payment for my care:

Name _____ Spouse Child Parent Other Relationship to Patient _____ Phone # _____

Name _____ Spouse Child Parent Other Relationship to Patient _____ Phone # _____

Name _____ Spouse Child Parent Other Relationship to Patient _____ Phone # _____

Check all that may apply:

- ☐ All my medical information
- ☐ Information necessary to schedule appointments for me
- ☐ Lab or test results
- ☐ Information necessary to provide, call in or pick up prescriptions for me
- ☐ Information necessary to provide, call in or pick up prescriptions for me
- ☐ Information necessary to help my family members(s) take care of me
- ☐ Information necessary to allow my family member(s) pick up or arrange for medical equipment to be provided for me
- ☐ Information necessary to bill for or submit claims for care provided to me to government or private insurance payers

My consent will remain in effect as long as I am a patient of Medical Arts Family Practice unless and until I notify Medical Arts Family Practice in writing of any changes.

Signature of Patient or Representative _____ Date _____

Print Name _____

Relationship of Representative to Patient _____

OVER

PATIENT ACKNOWLEDGE AND CONSENT

Patient Name _____ Chart # _____

I have been given a copy of Medical Arts Family Practice's Notice of Privacy Practices, version effective **September 23, 2013**. I consent to the uses and disclosures of my health information as outlined in the Notice.

Signature of Patient or Representative _____ Date _____

Print Name _____

Relationship of Representative to Patient _____

Please describe the Representative's authority to act on behalf of Patient: _____

_____

_____

FOR Medical Arts Family Practice USE ONLY

If acknowledgement of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain acknowledgment and the reason you could not obtain it:

_____

_____

_____

_____

Medical Arts Family Practice, PA
NC Health Information Exchange Consent

Select one option below:

- Full Opt-In –Medical Arts Family Practice, PA may share my health information with the NC HIE.

- Partial Opt-Out – NC HIE may not share my health information maintained by Medical Arts Family Practice, PA. In cases of medical emergency, my health record can be shared to diagnose or treat my emergency.

- Full Opt-Out –Medical Arts Family Practice, PA may not share any of my health information. *Please note that Medical Arts Family Practice, PA is subject to HIPAA and NC laws pertaining to the disclosure of certain health information such as reporting public health threats. In cases of medical emergency, a doctor may request to view health information to diagnose or treat a patient.

_____
Patient name (PRINT)

_____
Patient/Guardian Signature

_____
Date

Medical Arts Family Practice, PA

Chart# _____

HEALTH HISTORY

Name: _____ Date of Birth: _____ Date: _____

Previous Physician: _____ Last visit: _____ Reason: _____

Race: _____ Marital status: _____ Gender: _____

MEDICAL HISTORY:

Have you ever been diagnosed with any of the following diseases?

1. ❑ Abuse (physical, sexual, verbal or emotional)	18.❑ Hernia
2. ❑ Alcoholism	19.❑ High cholesterol, High blood pressure, Stroke
3. ❑ Anemia, Sickle Cell Disease or Trait, Blood disorder	20.❑ HIV, AIDS
4. ❑ Anorexia, Bulimia, other eating disorders	21.❑ Kidney or bladder problems, stones, dialysis
5. ❑ Arthritis, joint problems, back problems	22.❑ Migraine or severe headaches
6. ❑ Asthma, Bronchitis, other breathing problems	23.❑ Pain or numbness in arms or legs
7. ❑ Birth defects, genetic problems, Cystic Fibrosis	24.❑ Physical disability
8. ❑ Bleeding problems, blood clots in legs or lung, etc.	25.❑ Prostate problems
9. ❑ Bowel problems	26.❑ Rectal pain or bleeding, hemorrhoids or “piles”
10.❑ Breast lumps, discharge, tenderness, other problems	27.❑ Rheumatic fever
11.❑ Cancers, tumors (including cervical or uterine)	28.❑ Seizures (“fits”)
12.❑ Depression, anxiety, mental illness	29.❑ Stomach pain, cramps, ulcers
13.❑ Diabetes (sugar problems)	30.❑ Thoughts of harming self or others
14.❑ Eye problems, blurred vision or spots	31.❑ Thyroid problems
15.❑ Fainting, dizzy spells	32.❑ Transfusions of blood or blood products
16.❑ Heart disease, heart problems, chest pain	33.❑ Tuberculosis
17.❑ Hepatitis, liver problems, gallbladder problems	

Do you have any other illness for which you see a doctor regularly? _____

Do you have any of the following problems?

Hearing Loss ( ) Yes ( ) No Last exam _____

Vision Loss ( ) Yes ( ) No Last exam _____

Dental problems ( ) Yes ( ) No Last exam _____

Screening Tests:	**When**	**Where**
Last Mammogram	_____	_____
Bone Density	_____	_____
Stress Test	_____	_____
Last Pap smear	_____	_____
Last Colonoscopy	_____	_____
Last Chest X ray	_____	_____

Other Physicians: (Opthalmologists, Cardiologists, Urologists, etc...)

_____ _____ _____

_____ _____ _____

SURGICAL HISTORY: (Hysterectomy, gallbladder removal, appendectomy, etc...)

Please list all surgeries and dates:

_____ _____ _____ _____

_____ _____ _____ _____

Health History continued -

CHILDHOOD DISEASE / Infectious Diseases

( ) Mumps	( ) Chickenpox	( ) Measles	( ) Rubella	( ) Rheumatic Fever
( ) Tetanus	( ) Whooping Cough	( ) Meningitis	( ) Hep A & B	( ) Scarlet Fever
( ) Other _____				

FAMILY HISTORY:

Have any of your family members been diagnosed with the following diseases and if yes, what is their relationship to you?

		Relationship			Relationship
AIDS or HIV positive	( ) Yes ( ) No	_____	High Blood Pressure	( ) Yes ( ) No	_____
Asthma	( ) Yes ( ) No	_____	Kidney Disease	( ) Yes ( ) No	_____
BPH/Prostatitis	( ) Yes ( ) No	_____	Liver Disease	( ) Yes ( ) No	_____
Blood Clots	( ) Yes ( ) No	_____	Lupus or rheumatoid arthritis	( ) Yes ( ) No	_____
Cancer	( ) Yes ( ) No	_____	Seizure Disorder	( ) Yes ( ) No	_____
Chronic Bronchitis	( ) Yes ( ) No	_____	Stroke	( ) Yes ( ) No	_____
Emphysema	( ) Yes ( ) No	_____	Thyroid Disease	( ) Yes ( ) No	_____
Diabetes	( ) Yes ( ) No	_____	Tuberculosis	( ) Yes ( ) No	_____
Glaucoma	( ) Yes ( ) No	_____	Ulcer/Reflux	( ) Yes ( ) No	_____
Heart Disease	( ) Yes ( ) No	_____	High Cholesterol	( ) Yes ( ) No	_____

SOCIAL HISTORY:

Caffeine? ( ) Yes ( ) No What?_____How much?_____How long?_____

Tobacco Use? ( ) Yes ( ) No What?_____How much?_____How long?_____

Alcohol Use? ( ) Yes ( ) No What?_____How much?_____How long?_____

Other drug use? ( ) Yes ( ) No What?_____How much?_____How long?_____

Exercise? ( ) Regularly ( ) Sporadically ( ) Never

Practice firearm safety? ( ) Yes ( ) No
Do you wear seat belts? ( ) Yes ( ) No
Exposure to secondhand smoke? ( ) Yes ( ) No

Carbon monoxide detectors in the home? ( ) Yes ( ) No
Smoke Detectors in the home? ( ) Yes ( ) No

Occupation: _____

Occupation hazards: ( ) Stress ( ) Hazardous substances ( ) Heavy Lifting

Highest level of education completed: _____

Religious Affiliation: _____

Do you have a healthcare power of attorney? ( ) Yes ( ) No

Do you have a living will? ( ) Yes ( ) No

Allergies:

Are you allergic to or do you have reactions to any of the following?

( ) Penicillin	( ) Cephlasporins	( ) Bee Stings
( ) Sulfa	( ) Tetracycline	( ) Foods
( ) Ampicillin	( ) IVP dye	( ) Pollen/grass/trees

Other Allergies: _____

Health History continued -

MEDICATIONS: (prescriptions, over the counter medications, herbal supplements)

NAME	DOSE	HOW OFTEN?

IMMUNIZATIONS:
Please list date given and where:

Tetanus _____

Pneumonia _____

Flu _____

Hepatitis A Series _____

Hepatitis B Series _____

TB Tine _____

Chicken Pox _____

MMR _____

Other _____

MEDICAL ARTS FAMILY PRACTICE

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provide, the release information may no longer be protected by federal privacy regulations.

I authorize_____ to disclose the following information from the medical records of:

Patient Name: _____ Date of Birth: _____

Address: _____

Telephone: _____ Patient Number: _____

Covering the period(s) of health care:

From _____ to _____

From _____ to _____

Information to be disclosed:

☐ Complete health record(s), including all images (x-rays, photographs, etc.)
☐ Complete health record(s), excluding all images

OR

Select from the following (check as many as apply):

☐ Discharge Summary
☐ History and Physical Examination
☐ Consultation Reports
☐ Progress Notes
☐ Laboratory Tests
☐ X-ray reports
☐ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection
☐ Treatment for alcohol and/or drug abuse
☐ Photographs, videotapes, digital or other images

☐ Other (please specify) _____

_____

This information is to be disclosed to the following ORGANIZATION:

_____

Address: _____

Telephone: _____ Fax: _____

_____

OVER

Reason for Disclosure: _____

The patient or the patient's representative must read and initial the following statements:

a. I understand that unless earlier revoked, this authorization will expire on __/__/__ or on the happening of _____

Initials: _____

b. I understand that I may revoke this authorization at any time by notifying Medical Arts Family Practice in writing, but if I do it won't have any effect on any actions Medical Arts Family Practice took before it received the revocation.

Initials: _____

c. I understand that Medical Arts Family Practice cannot make me sign this authorization as a condition to receive treatment from Medical Arts Family Practice except:

(i) when Medical Arts Family Practice provides me with research-related treatment; or

(ii) when Medical Arts Family Practice provides me with health care solely for the purpose of creating protected health information for disclosure to someone else.

Initials: _____

Medical Arts Family Practice, its employees, officers, and physicians are hereby released from any legal responsibility for disclosure of the above information to the extent indicated and authorized herein.

(Form MUST be completed before signing)

_____
Signature of Patient or Representative

_____
Date

_____
Print Name

_____
Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of the Patient:

_____

_____

**** YOU MAY REFUSE TO SIGN THIS AUTHORIZATION****