

**Carrboro Family Medicine Center**

*Review of Systems*

Name: \_\_\_\_\_  
Date: \_\_\_\_\_

Physician: \_\_\_\_\_  
Chart#: \_\_\_\_\_

Yes	No	<u>General:</u>	<u>(Comments to be completed by provider)</u>
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___	___	Loss of appetite	
___	___	Fatigue	
___	___	Fever	
___	___	Change in weight	
___	___	Do you smoke?	
___	___	if so, do you wish to quit?	
___	___	Do you drink alcohol?	
___	___	if so, over two drinks daily?	
___	___	Follow low cholesterol diet?	
___	___	Exercise	
___	___	How many hours a week?	
___	___	Date of last Tetanus shot	

Skin:

___	___	Skin problems	
___	___	Unusual or changed moles	

Head, eyes, ears, nose, throat:

___	___	Date of last dental exam	
___	___	Date of last eye exam	
___	___	Eye/Vision problems	
___	___	Nasal congestion	
___	___	Runny nose	
___	___	Hearing difficulty	
___	___	Chronic sore throat	

Neck:

___	___	Swollen glands	
___	___	Respiratory:	
___	___	Chronic cough	
___	___	Shortness of breath	
___	___	Wheezing	

Breast:

___	___	Monthly self breast exam	
___	___	Breast mass	
___	___	Breast pain	
___	___	Nipple discharge	
___	___	Skin changes	

Cardiovascular:

___	___	Chest pain or tightness	
___	___	Edema or swollen ankles	
___	___	Palpitations	
___	___	Wake up suffocating	

**Please continue on the back of this form.**

Yes	No	<u>Gastrointestinal</u>	<u>(Comments to Be Completed By Provider)</u>
_____	_____	Date of last sigmoid/colonoscopy	
_____	_____	Abdominal pain	
_____	_____	Constipation	
_____	_____	Diarrhea	
_____	_____	Difficulty Swallowing	
_____	_____	Frequent Heartburn	
_____	_____	Hemorrhoids	
_____	_____	Blood in stool or black stool	
_____	_____	Nausea or vomiting	

	<u>Female Genitourinary</u>	<u>Male Genitourinary</u>	Yes	No
_____	Date of last menstrual period	Painful urination	_____	_____
_____	Date of last bone density	Pink/red urine	_____	_____
_____	Date of last mammogram	# urinations at night	_____	_____
_____	Date of last PAP	Testicular exam	_____	_____
_____	History of abnormal PAP	Monthly testicular exam	_____	_____
_____	Pain with intercourse	Penile discharge	_____	_____
_____	Painful urination			
_____	Pink/red urine			
_____	Incontinence of urine			
_____	Menstrual problems/irregularity			
_____	Form of contraception			
_____	Vaginal discharge			
_____	Worried about sexual diseases			

<u>Musculoskeletal</u>	
_____	Back or neck pain
_____	Joint pain
_____	Joint swelling
_____	Muscle pain

<u>Neurological</u>	
_____	Dizziness or fainting
_____	Frequent or severe headaches
_____	Numbness
_____	Weakness in extremities

<u>Psychiatric</u>	
_____	Anxiety or Nervousness
_____	Depression
_____	Insomnia or change in sleep
_____	Irritability

<u>Endocrine</u>	
_____	Cold intolerance
_____	Hair loss
_____	Heat intolerance
_____	Hot flashes
_____	Decreased libido
_____	Sexual dysfunction

<u>Hematology</u>	
_____	Enlarged lymph nodes

Current meds:

Herbs or supplements:

Seeing any Specialists (indicate name and reason):

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CARRBORO FAMILY MEDICINE CENTER, PA

**Patient Information**

Name \_\_\_\_\_  
Last Name First Name Initial  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Sex: M \_\_\_ F \_\_\_ Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_  
Work Phone \_\_\_\_\_ Name of Employer \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

**Guarantor Information**

Relationship to Patient: Spouse \_\_\_ Parent \_\_\_ Other \_\_\_  
Name \_\_\_\_\_  
Last Name First Name Initial  
Address (if different) \_\_\_\_\_ Home Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Sex: M \_\_\_ F \_\_\_ Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_  
Employer Name and Work Phone \_\_\_\_\_

**Primary Insurance**

Insurance Name \_\_\_\_\_  
Subscriber ID # \_\_\_\_\_ Group # \_\_\_\_\_ Effective date \_\_\_\_\_  
Claim Address and Phone Number \_\_\_\_\_  
Subscriber Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

**Secondary Insurance**

Insurance Name \_\_\_\_\_  
Subscriber ID # \_\_\_\_\_ Group # \_\_\_\_\_ Effective date \_\_\_\_\_  
Claim Address and Phone Number \_\_\_\_\_  
Subscriber Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

## Disclosures & Consents

### **ASSIGNMENT OF INSURANCE BENEFITS:**

I hereby authorize direct payment of my insurance benefits to Carrboro Family Medicine Center, PA or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Carrboro Family Medicine Center, PA is unable to collect from my insurance carrier for whatever reason.

### **MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:**

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct the payment of my or my dependent's authorized benefits be made directly to Carrboro Family Medicine Center, PA or the physician on my behalf.

### **AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL HEALTH INFORMATION (PHI):**

I certify that I have read and received a copy of the Carrboro Family Medicine Center, PA Notice of Privacy Practices. I hereby authorize Carrboro Family Medicine Center, PA or the physician individually to release any of my or my dependent's medical or incidental non-public personal health information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

### **AUTHORIZATION TO MAIL, CALL OR EMAIL:**

I certify that I understand the privacy risks of the mail, phone calls and e-mail. I hereby authorize a Carrboro Family Medicine Center, PA representative or my physician to mail, call, or e-mail me with communication regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Carrboro Family Medicine Center, PA to that effect in writing.

### **LAB/X-RAY/DIAGNOSTIC SERVICES:**

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for services if they are not reimbursed by my insurance for whatever reason.

### **CONSENT TO TREATMENT:**

I hereby consent to evaluation, testing, and treatment as directed by my Carrboro Family Medicine Center, PA physician or his/her designee.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

GUARANTOR SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

GUARANTOR PRINTED NAME \_\_\_\_\_

## Carrboro Family Medicine Center, PA Notice of Privacy Practices

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

This notice is effective on March 1, 2007. This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted by law, it also describes your rights to access your protected health information. "Protected Health Information" is information about you, including demographic information, which may identify you and relates to your past, present or future physical or mental health or condition and related health care services. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time.

### **USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION or PHI**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that is involved in your care and treatment for the purpose of providing health care services to you. Your PHI may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice. The following are examples of the types of uses and disclosures of your PHI that the physician's office is permitted to make.

**Treatment.** We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party, such as a home health agency that has already obtained your permission to have access to your PHI. We will also disclose PHI to other physicians, specialists or laboratories that may be treating you or to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment.** Your PHI will be used as needed to obtain payment for your health care services. This may include certain activities that your health insurance plan may require before it approves or pays for the health care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and medical record review activities. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations.** We may use or disclose as needed, your PHI in order to support the business activities of Carrboro Family Medicine Center, PA. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the front desk and we may call you by name in the waiting room when your physician is ready to see you. We may also use or disclose your PHI, as necessary to contact you to remind you of your appointment. For example: we may leave a message on you answering machine at home or work to confirm your appointment unless you specify otherwise. We will share your PHI with third party "business associates that perform various activities for the practice such as billing and transportation services. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI. We may use or disclose your PHI as necessary, to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you. We may also use and disclose your PHI or other marketing activities. For example, your name and address may be used to send you information about products or services that we believe may be beneficial to you or send you a newsletter about our practice and the services we offer. You may contact our privacy officer to request that these materials not be sent to you.

**Patient Initials:** \_\_\_\_\_

**Others involved in you Healthcare.** Unless you object we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

**Emergency.** We may use or disclose your PHI in an emergency treatment situation.

**Required by law.** We may use or disclose your PHI to the extent that is required by law. You will be notified of any such uses or disclosures.

**Public Health.** As required by law, we may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury or disability. We may also disclose your PHI, if authorized by law to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

**Health Oversight.** We may disclose your PHI to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

**Abuse and Neglect.** We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

**Food and Drug Administration.** We may disclose your PHI to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, and tracking of products to enable product recalls, make repairs or replacements, or to conduct post marketing surveillance as required.

**Legal Proceedings.** We may disclose your PHI in the case of any judicial or administrative proceeding, in response to an order of a court, subpoena, discovery requestor or other lawful process.

**Law Enforcement.** We may also disclose your PHI, as long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include legal processes required by law, limited information requests for identification and location purposes, pertaining to victims of a crime, suspicion that a death has occurred as a result of criminal conduct, in the event that a crime occurs on the premises of the practice and medical emergency (not on the practice's premises) and it is likely that a crime has occurred.

**Coroners, Funeral Directors, and Organ Donation.** We may disclose PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. PHI may be used and disclosed for cadaver organ, eye or tissue donation purposes.

**Research.** We may disclose your PHI to researchers when their research has been approved by a institutional review board that has reviewed the research proposal and established protocols ensuring the privacy of your PHI.

**Criminal Activity.** Consistent with applicable federal and state laws, we may disclose your PHI, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose your PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

**Patient Initials:** \_\_\_\_\_

**Military Activity and National Security.** When the appropriate conditions apply, we may use or disclose your PHI to individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities, for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits or to foreign military authority if you are a member of that foreign military services. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

**Workers' Compensation.** Your PHI may be disclosed as authorized to comply with workers compensation laws and other similar legally established programs.

**Required Uses and Disclosures.** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Federal Law. Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physicians practice has already taken an action relying on the use of your previously signed authorization.

**YOUR RIGHTS:** Following is a statement of your rights with respect to your PHI and a brief description of how you may exercise these rights.

**You have the right to obtain a copy of your PHI.** This means you may obtain a copy by providing our staff with a written request for your designated record set. A "designated record set" contains medical records and any other records that your physician and the practice use for making decisions about you. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information being compiled in reasonable anticipation of or in use in a civil, criminal, or administrative action or proceeding, and any other records that are subject to Federal or State law. Depending on the circumstances, your request may be denied. You may have the right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

**You have the right to request a restriction of your PHI.** This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your PHI, your information will not be restricted. If your physician does agree to the request, we may not violate that restriction unless it is needed to provide emergency treatment. With this in mind please discuss any restriction you may wish to request with your physician. You may request a restriction by providing a written request to our Privacy Officer, Mrs. Erin Hinrichs.

**You may have the right to have your physician amend your PHI.** This means you may request an amendment of PHI about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

**You have the right to receive an accounting of certain disclosures we have made, if any of your PHI.** This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in the Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred. The right to receive this information is subject to certain exceptions, restrictions and limitations.

**COMPLAINTS:** You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Officer of your complaint. You may contact our Privacy Officer, Erin Hinrichs by telephone at 919-929-1747 option 7 or in writing to: Carrboro Family Medicine Center, PA Attention: Mrs. Erin Hinrichs, Practice Manager, 601 Jones Ferry Road, Suite 102, Carrboro, NC 27510 for further information about the complaint process.

**Patient Initials:** \_\_\_\_\_

**Acknowledgement of Receipt of Notice**

**I acknowledge that I have been given a copy of Carrboro Family Medicine Center, PA**

**Notice of Privacy Practices, dated March 1, 2007**

**Date:** \_\_\_\_\_

**Name of Patient or Patient Representative:** \_\_\_\_\_

**Signature of Patient or Patient's Representative:** \_\_\_\_\_

**Relationship of Patient's Representative to Patient:** \_\_\_\_\_

**Evidence of authority of the Patient's representative:** \_\_\_\_\_  
**(Attach evidence to this page to be filed in chart)**

**Carrboro Family Medicine, PA  
Financial Policy**

Thank you for choosing Carrboro Family Medicine to serve your family's health care needs. We are pleased to be able to participate in your family's health care and look forward to a lasting relationship as your primary health care provider. As part of this relationship, we wish to establish our expectations of your financial responsibility as outlined in our Financial Policy. We can often help with filing claims, but you are primarily responsible for any charges that you have incurred as a patient with Carrboro Family Medicine. Please review and sign the following financial policy prior to your office visit.

**CO PAYMENTS, DEDUCTIBLES, AND FEES:** All co payments, insurance deductibles, and fees for services not covered by your insurance policy are due at time service is rendered. We accept cash, check, MasterCard, Visa, Discover and American Express. Also there is a \$25.00 charge for any returned check.

**INSURANCE:** You must bring your current insurance card(s) with you to each appointment. Our office will gladly file your insurance if we are given the correct information. If you give us incorrect insurance information, we may not be able to get a retro referral for office visit and/or precert for procedures leaving the patient responsible for the total charge. Patients who do not present an insurance card or have no insurance will be responsible for payment at the time of service unless other arrangements are made with our billing department prior to service. In the event your insurance company does not cover a service rendered, you understand you will be financially liable for the medical service and/or supplies. It is the patient's responsibility for knowing the details of your coverage, as it is a contract between you and your insurance company.

According to NC Statute 58-2253, insurers are required to pay a properly submitted claim within 30 days. You have a responsibility to provide information to our office so a claim can be properly submitted. If your insurance company has not paid a claim on your behalf within 90 days because of information you have not provided, the balance will be transferred to your account and you are responsible for payment. If we receive payment at a later date, you will be reimbursed by Carrboro Family Medicine Center, PA.

**MINORS AND DEPENDENTS:** Parents and guardians are responsible for payment for their dependents at the time the service is rendered. Minors and dependents must present a valid insurance card at each visit if a claim is to be filed. See INSURANCE section above if an insurance card is not presented.

**MISSED APPOINTMENTS:** Unless cancelled at least 24 hours in advance, our policy is to charge for certain missed appointments. The fee for a missed Complete Physical Exam is \$35.00. This fee is not covered under your insurance plan and is your responsibility.

**WALK IN / URGENT CARE:** In the case of a walk in / Urgent Care visit your insurance will be billed a separate charge of \$75.00. This fee may or may not be covered by your insurance; in the case that it is not covered you will be responsible for the fee.

**PROMPT PAYMENT:** If you have a hardship or are unable to pay your bill in its entirety, please contact our billing department to discuss payment options. If your account becomes delinquent and you have not established payment options with our billing department your account will be turned over to a collection agency, in this event you can not schedule any type of appointment or receive any prescribed medications until the debt is paid in full.

I have read the Financial Policy and agree to its terms.

\_\_\_\_\_  
Patient/Guarantor signature      Date

**Carrboro Family Medicine Center, PA**  
**Patient consent for use or Disclosure of Protected Health Information (PHI)**

**If we are unable to reach you, are there any relatives or friends with whom you authorize our office to discuss your health information?**

\_\_\_\_\_ **YES**                      \_\_\_\_\_ **NO**      **If so, please list their names below:**

**Name** \_\_\_\_\_ **Relationship** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Name** \_\_\_\_\_ **Relationship** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Name** \_\_\_\_\_ **Relationship** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Name** \_\_\_\_\_ **Relationship** \_\_\_\_\_ **Phone** \_\_\_\_\_

**By my signature, I authorize you to discuss my health information with those individuals indicated above. This authorization will be in effect until revoked in writing.**

\_\_\_\_\_  
**Patient/ Guarantor Signature**

\_\_\_\_\_  
**Date**