



Breezewood Family Healthcare, P.A. REGISTRATION FORM

Office Use Only

Patient ID:

(Please Print)

Today's Date:	PCP:
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PATIENT INFORMATION

Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status:	
				Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>			
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):			Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone no.: ()		
P.O. box:		City:		State:		ZIP Code:	
Occupation:		Employer:			Employer phone no.: ()		
Chose clinic because/referred to clinic by (Please check one box):				<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance plan	<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other			
Other family members seen here:							

E-mail Address: _____ May we contact you at this address? Yes No

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:		Birth date:	Address (if different):		Home phone no.: ()	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Occupation:		Employer:	Employer address:			Employer phone no.: ()
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Please indicate insurance: Primary, Secondary, Tertiary		<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>			<input type="checkbox"/> Medicaid <i>(Please provide coupon)</i>		<input type="checkbox"/> Other	
Subscriber's name:		Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: \$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	
Name of secondary insurance (if applicable):		Subscriber's name:			Group no.:	Policy no.:
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	

IN CASE OF EMERGENCY

Name of local friend or relative:		Relationship to patient:	Home phone no.: ()	Work phone no.: ()
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Breezewood Family Healthcare, P.A. or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date



FINANCIAL POLICY

PAYMENT RESPONSIBILITY

The patient or their legal representative is ultimately responsible for all charges incurred. It is the patient or legal representative's responsibility to keep this office informed of any change in information. It is our policy not to discuss a patient's account information or medical record with anyone other than the patient unless the patient gives prior written consent in accordance with HIPAA regulations.

ASSIGNMENT OF BENEFITS

Breezewood Family Healthcare, P.A. will bill insurance plans that we are a contracted provider for as a courtesy to our patients if the patient provides the required insurance information, both primary and secondary (if applicable), and signs an assignment of benefits statement (located on the patient registration form). Your insurance contract is an agreement between you and your insurance carrier. Any deductibles, co-pays and coinsurance are **due at the time of the visit**.

PARTIAL INSURANCE COVERAGE

Patients with insurance policies that cover only a portion of treatment must pay the difference between actual charges and anticipated insurance reimbursement. This payment is due at the time of service. A pre-treatment deposit may be required. Failure to pay this may cause the patient's appointment for that day to be rescheduled.

UNINSURED PATIENTS/NON-COVERED SERVICES

Payment of all charges, which are not covered by insurance, are due at the time of service. This would apply to deductibles, co-pays and coinsurance. A pre-treatment deposit may be required. Failure to pay this may cause the patient's appointment for that day to be rescheduled.

VERIFICATION OF INFORMATION

All information provided regarding the ability to pay, third party insurance, employment, etc. will be subject to verification.

UNPAID INSURANCE BALANCES

Patients are required to make full payment of unpaid balances when insurance payments are not received after 60 days from the first date of billing.

THIRD PARTY LITIGATION

Breezewood Family Healthcare, P.A. will not become involved in disputes arising from third party claims (i.e. automobile accidents, liability claims, workman's comp, etc.). In these events, the patient will be responsible for payment at the time of their visit and may make their own claim to the involved party for reimbursement.

PAYMENT ARRANGEMENTS

If a patient is unable to make full payment of their balance due, payment arrangements may be made on an individual basis subject to verification of financial hardship. A minimum payment of 25% of the balance must be made in order for a payment arrangement to be considered. This is with the understanding that the remaining balance is to be paid over a three-month period. These accounts may be subject to an account maintenance fee of \$2.00 for each bill sent out after 60 days. Interest will accrue on any unpaid balance at a rate of 1.5% per month.

PAYMENT METHODS

Cash, check, money orders, Visa, MasterCard, American Express, Discover, and EFT (Electronic Funds Transfer) are all acceptable payment methods.



FINANCIAL POLICY
(cont.)

NONSUFFICIENT FUNDS (NSF)

If a check is returned for nonsufficient funds, you will be charged a fee of \$25.00 for each NSF check in addition to the amount owed. Your insurance will not cover this charge. Patients with checks returned due to nonsufficient funds **MUST** make future payments by cash, credit card or money order. Failure to do so may result in discharge from the practice.

REFERRAL FOR OUTSIDE COLLECTION

Accounts which cannot be collected after normal in-house collection efforts have been exhausted, may be referred to a collection agency, magistrate, or attorney for further collection action. If your account is sent to collections, you will be discharged from the practice.

REFUNDS

Overpayments will be refunded to the appropriate party, normally the insurance company or guarantor. Patients' refunds will not be processed until all active or past due accounts are paid in full. These are normally refunded within 30 days.

If you have any questions regarding this policy, please contact our Office Manager for further clarification.

I have read and understand this Financial Policy. I agree to the terms outlined above.

Printed Name of Patient/ Responsible Party

Date

Patient or Responsible Party Signature

Date

Relationship to Patient



**GENERAL OFFICE
POLICY**

APPOINTMENTS

Patients are seen by appointments only. Every effort will be made to address urgent care issues. There may be days when a same day appointment is not available. Please call if you are going to be late for an appointment. Out of respect for other patients, if you are more than 10 minutes late for your appointment, you may be asked to reschedule. We try to respect your time, as we know everyone is busy. We try to see our patients within 20 minutes of their appointment time. If you are early for your appointment, we will try to accommodate you without inconveniencing other patients. You may need to wait for your allotted appointment time. When our practitioners are running behind, it is usually because of an unusual or emergent situation. We ask that you be patient during these times. You will receive the same attention if you should ever have an emergent need.

FAILURE TO KEEP SCHEDULED APPOINTMENTS

Please call 24 "business hours" in advance to cancel an appointment. This will allow us to give that time to another patient and schedule you for a more convenient time. There is a cancellation fee of \$25.00 for an office visit and a \$50.00 fee if the visit was scheduled for a procedure or physical exam when appointment is not cancelled within the 24 "business hour" time period. These charges are the patients or his/her legal representative's responsibility and are not billable to your insurance. Three failures to keep scheduled appointments may result in dismissal from the practice. Whether or not you're discharged is up to the discretion of your practitioner.

PRESCRIPTIONS AND REFILLS

We require a 48 hour notice for prescription refills. When you notice that only a few days worth of medication are left in your bottle, please let us know so that there will not be an interruption in your regimen. Some medical conditions can have severe consequences when medication is missed, Breezewood Family Healthcare, P.A. will make every effort to warn you of these conditions but it is always safer not to run out of your medication at all. Regular appointments will monitor the effects of your medication. If there has not been an appointment within an appropriate interval, your refill amount may be limited. Lost/misplaced prescriptions or changing pharmacy will incur a charge of \$10.00 per prescription.

TEST RESULTS

You will receive notice of test results by mail or phone. It is the patients responsibility to keep us informed of any changes to your address and/or phone number so that we can provide results in a timely manner. You may be asked to make an appointment to discuss the results. If you've received results in the mail but still have questions, you are always welcome to make an appointment to discuss them further.

AFTER HOURS SERVICE

We have an after-hours Emergency Answering Service. ***This is for urgent problems only.*** We will not refill medications outside of regular office hours. If a treatment is recommended or prescribed over the phone, without an office visit, you may be charged \$20.00 for this urgent consultation. This charge is your responsibility and is not billable to your insurance.

FORM COMPLETION

Because of the time and effort required, there will be a charge for completing forms. We do not charge for school or DOT physical forms as long as they are done in conjunction with an office visit. There is a charge of \$10 per page if the form is brought in *after* a visit. There is a charge of \$10.00 per page not to exceed \$30.00 for disability and other types of forms. This charge is your responsibility and is not billable to your insurance.



**Breezewood Family
Healthcare, P.A.**

**GENERAL OFFICE
POLICY (cont.)**

Patient Acct. No. _____

MEDICAL RECORDS

Requests for medical records require at least 72 "business hours" notice. There is a charge to the patient as per the following scale:

Pages 1 thru 13	Total \$10.00
Pages 14 thru 100	Additional \$0.50/page
Pages 101 and above	Additional \$0.25/page
CD ROM	Total \$15.00

We will be more than happy to release your medical records to another provider at no cost to you. A medical record release with all pertinent information needs to be filled out prior to the release of said records.

LAB WORK

As a courtesy to our patients, we draw lab work in our office to send to Quest Diagnostics or LabCorp. As directed by your insurance, labs will be billed through our office or through your insurance company. If you receive a bill for lab work, you can clarify this through the company which sent you the bill. There will be a charge for drawing labs, which may be billed by our office or by the lab. Lost/misplaced lab slips will incur a \$10.00 replacement fee. This fee is your responsibility and is not billable to your insurance. Breezewood Family Healthcare accepts no liability for lab charges that are not deemed medically necessary or covered by your insurance.

VERBAL ABUSE

Any verbal abuse, profanity, or threatening remarks made toward staff, other patient's or anyone else in the building by a patient or a patient's family member will be grounds for immediate dismissal from the practice. Threatening remarks will be grounds for removal from the building and possible legal action.

If you have any questions regarding this policy, please contact our Office Manager for further clarification.

I have read and understand this General Office Policy. I agree to the terms outlined above.

Printed Name of Patient/Responsible Party

Date

Patient or Responsible Party Signature

Date

Relationship to Patient



*Breezewood Family
Healthcare, P.A.*

**PATIENT CONSENT
FORM**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

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

I have been informed by you of your Notice of Privacy Practices containing a more complex description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand 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 Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____



Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize Breezewood Family Healthcare, P.A. to use and/or disclose certain protected health information (PHI) about me to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

Name(s) of other individual(s) (your Spouse and/or Dependent Children), about whom information may be used and/or disclosed to: _____

Method of contact: ___ home phone ___ cell phone ___ work phone ___ e-mail

I have been informed that I may review the practice's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire one year from today.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.

I do not have to sign this authorization in order to receive treatment from Breezewood Family Healthcare, P.A. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Office Manager at:

**Breezewood Family Healthcare, P.A.
P.O. Box 87448
Fayetteville, NC 28304-7448**

Signed By: _____
Signature of Patient or Legal Guardian Relationship to patient

Print Patient's Name Date

Print name of Patient or Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of this authorization form.

Print name of Patient or Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of this authorization form.



**Breezewood Family
Healthcare, P.A.**

**Acknowledgement &
Authority for Treatment &
Payment**

PATIENT NAME:

DOB:

ACCOUNT NO.:

Initial

____ I consent to treatment as necessary or desirable to the care of the patient named above, including but not restricted to whatever drugs, medicine, performance of operations and conduct of laboratory, x-ray, or other studies that may be used by the attending doctor/provider, his/her nurse or qualified designate.

____ I also acknowledge full responsibility for the payment of such services and agree to pay for them upon demand, in full, AT THE TIME OF SERVICE. If the physician must use a collection agency/attorney or court to collect its charges, then I will pay reasonable attorney fees and costs incurred in collecting same, regardless of insurance coverage.

____ I hereby authorize payment directly to Breezewood Family Healthcare, P.A. of the medical expense benefits otherwise payable to me but not to exceed my indebtedness to said physician on account of the enclosed charge.

____ I understand that this is not a walk-in clinic and that scheduled appointments are necessary. I also understand that a 24 "business hour" notice is required for cancellation or rescheduling of appointments. There is a cancellation fee of \$25.00 for an office visit and a \$50.00 fee if the visit was scheduled for a procedure or physical exam. These charges are my responsibility and are not billable to my insurance.

____ I hereby authorize any medical practitioner, medical or medically related facility, insurance or reinsuring company, consumer reporting agency, or employer having information with respect to any physical or mental condition and/or treatment of me or my minor children and any other non-medical information of me and my minor children to give to the group policyholder, my employer, or its legal representative, any and all such information if requested.

____ I understand the information obtained by the use of the Authorization will be used to determine eligibility for insurance, and eligibility for benefits under any existing policy. Any information obtained will not be released by/to any organization EXCEPT to the group policyholder, my employer, reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required or as I may further authorize.

____ I further agree that a photographic copy of this Authorization shall be valid as the original. This Authorization shall be valid for one year from the date shown below.

Printed Name of Patient/Responsible Party

Date

Patient or Responsible Party Signature

Date

Relationship to Patient



Adult Health History Form

Name

Date

Your answers on this form will help your practitioner better understand your medical concerns and conditions. This form will not be put directly into your medical chart. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please provide your best guess. Thank you!

Age: _____ How would you rate your general health? Excellent Good Fair Poor

Main reason for today's visit: _____

Other concerns: _____

Table with 3 columns: Constitutional, Respiratory, Skin, Gastrointestinal, Neurological, Psychiatric, Blood/Lymphatic, Endo, Musculoskeletal. Rows include symptoms like fevers, cough, rash, etc.

In the past month, have you had little interest or pleasure in doing things, or felt down, depressed or hopeless?

Yes No

Allergies to food/environmental or reactions to medications:

Table with 2 columns: Allergy/Medication, Reaction

Dates of your most recent IMMUNIZATIONS:

Hepatitis A _____ Hepatitis B _____ Influenza _____ MMR _____ Pneumova _____
Meningitis _____ Tetanus (Td) _____ Varicella (chicken pox) or illness _____ Tdap _____

HEALTH MAINTENANCE SCREENING TESTS:

Last Eye Exam: When _____ Where _____ Abnormal? Yes No

Last Dental Exam: When _____ Where _____

Last Hearing Exam: When _____ Where _____

Lipid (cholesterol) _____ Date _____ Abnormal? Yes No

Sigmoidoscopy or Colonoscopy Date _____ Where _____ With whom _____
Abnormal? Yes No

Women: Mammogram Date _____ Where _____ With whom _____
Abnormal? Yes No

Pap Smear: Date _____ Where _____ With whom _____
Abnormal? Yes No

Dexascan (osteoporosis) Date _____ Where _____ Abnormal? Yes No

Men: PSA (prostate) Date _____ Where _____ With whom _____
Abnormal? Yes No

Stress Test: with contrast without contrast Date _____ Where _____
With whom _____ Abnormal? Yes No

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following medical problems (with dates).

- Heart disease: _____ High blood pressure: _____ High cholesterol _____
 Diabetes (specify type) _____ Thyroid problem _____
 Asthma/Lung disease _____ Other: (specify): _____ Kidney disease: _____
 Cancer: (specify): _____

Do you see any specialist currently or in the past? Yes No (Please list below.)

SURGICAL HISTORY: Please list all prior operations (with dates & by whom):

FAMILY HISTORY: Please indicate the current status of your immediate family members:

Medical Condition	Mom	Dad	Sis.	Bro.	Dau.	Son	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Mom's Sis.	Mom's Bro.	Dad's Sis.	Dad's Bro.
Deceased:														
Cause of Death:														
Alcoholism														
Bleeding problems														
Cancer, Breast														
Cancer, Colon														

Medical Condition	Mom	Dad	Sis.	Bro.	Dau.	Son	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Mom's Sis.	Mom's Bro.	Dad's Sis.	Dad's Bro.
Cancer, Melanoma														
Cancer, Ovary														
Cancer Prostate														
Heart Attack/Heart Disease														
Depression														
Diabetes, on insulin shots														
Diabetes, not on insulin														
High Cholesterol														
High Blood Pressure														
Stroke														
Substance abuse														
Thyroid disorders														

SOCIAL HISTORY

Tobacco Use

Cigarettes: Never Quit If quit: Date or how long: _____ How may packs/day? _____

Current Smoker: packs/day _____ # of yrs _____

Other Tobacco: Pipe Cigar Snuff Chew

Are you interested in quitting? No Yes If yes what have you tried in the past? _____

Alcohol Use

Do you drink alcohol? No Yes # drinks/week _____

Is your alcohol use a concern for you or others? No Yes

Drug Use

Have you ever used any recreational drugs? No Yes Currently use? No Yes

If yes, what? _____

Have you ever used needles to inject drugs? No Yes

Sexual Activity

Sexually active: Yes No Not currently How long? _____

Current sex partner(s) is/are: male female # of current partners _____ # of lifetime partners _____

Birth control method: None needed What type of birth control if currently using? _____

Have you ever had any sexually transmitted diseases (STDs)? No Yes If yes, what _____

Was it treated No Yes

Are you interested in being screened for sexually transmitted diseases? No Yes

OTHER CONCERNS

Pets: Yes No What kind? _____

Caffeine Intake: None Coffee/tea/soda _____ cups/day

Diet: How do you rate your diet? Good Fair Poor

Do you eat or drink four servings of dairy or soy daily or take calcium supplements? No Yes

Exercise: Do you exercise regularly? No Yes

What kind of exercise? _____

How long (minutes) _____ How often? _____

If you do not exercise, why? _____

Safety:

Do you use a bike helmet? No Yes NA

Do you use seatbelts consistently? No Yes

Is violence at home a concern for you? Yes No

Have you ever been abused? Yes No

Do you have a gun in your home? Yes No

Have you completed a living will or durable power of attorney for health care? Yes No

SOCIOECONOMICS

Occupation: _____ Employer: _____

Years of education/highest degree: _____

Marital Status: Single Partner/Married Divorced Widowed Other: _____

Spouse/partner's name: _____ Number of children/ages: _____

Who lives at home with you? _____

WOMEN'S HEALTH HISTORY

Pregnancies: _____ # Vaginal deliveries: _____ # C-section deliveries: _____

Full term births: _____ # abortions: _____ # miscarriages: _____

Any complications during pregnancy/delivery No Yes

MENSTRUAL CYCLE

Age at start of periods: _____ Age at end of periods: _____

Regular Irregular How many days do cycle last? _____

Menstrual Flow: Light Normal Heavy

