Allmed Clinic, PA
3708 Forestview Rd, Suite 207
Raleigh, NC 27612
Phone: (919) 781-8780
Fax: (919) 781-8782

New Patient Registration Form

Name: _____
LAST FIRST M.I.

Sex: [❍ female ❍ male] Date of Birth: _____–_____–_____ SSN: _____
MM DD YYYY

Mailing Address: _____

City: _____ State: _____ Zip: _____

Physical Address (*if different*): _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ – _____ Work Phone: (_____) _____ – _____

Cell Phone: (_____) _____ – _____

Which number may we leave a BRIEF OR EXTENDED MESSAGE? _____

Email Address: _____

Check One Status: [❍ single ❍ married ❍ widowed ❍ separated ❍ divorced]

Employer: _____ Occupation: _____ [❍ full-time ❍ part-time]

Emergency Contact Name: _____ Relationship to Patient: _____

Phone: (_____) _____ – _____

Check One Race: [❍ African-American ❍ Caucasian ❍ Latino/a ❍ South Asian-American

❍ East Asian-American ❍ Native American ❍ Mixed/Other _____]

Check One: [❍ Hispanic ❍ non-Hispanic]

Primary Language: [❍ English ❍ Spanish ❍ Other _____]

— Please have insurance cards present at every visit. —

Primary Insurance Name: _____ ID#: _____
Sponsor/Subscriber Name: _____ SS#: _____
Relationship to Patient: [❍ self ❍ spouse ❍ parent ❍ other _____]
Secondary Insurance Name: _____ ID#: _____
Sponsor/Subscriber Name: _____ SS#: _____
Relationship to Patient: [❍ self ❍ spouse ❍ parent ❍ other _____]

Local Pharmacy Name: _____ Phone: (_____) _____ – _____
Address: _____
Fax: (_____) _____ – _____

How did you hear about us? _____

_____ _____
PATIENT/REPRESENTATIVE SIGNATURE DATE

If signed by a guardian/representative:

_____ _____
REPRESENTATIVE NAME RELATIONSHIP TO PATIENT

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Consent for Release of Protected Health Information to Family

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

_____ _____
NAME OF PERSON **NAME OF PERSON**

Check the type of information that you consent to having shared with this person/these people (if anyone):

- ❍ 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 help my family member(s) take care of me
- ❍ Information necessary to allow my family member(s) to 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 payors

Consent for Communication of Protected Health Information to Patient

Leave a message on my answering machine or voicemail: [❍ yes ❍ no]
Mail medical information to my home address: [❍ yes ❍ no]
If no, please give another mailing address: _____

Check the type of information that you consent to having shared with you through the selected communication methods above, if any:

- ❍ 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 help my family member(s) take care of me
- ❍ Information necessary to allow my family member(s) to 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 payors

My consent will remain in effect as long as I am a patient of Allmed Clinic, PA, unless and until the event that I notify Allmed Clinic, PA, in writing of any changes.

_____ _____
PATIENT/REPRESENTATIVE SIGNATURE **DATE**

Although allowed under HIPAA, North Carolina law does not permit the release of PHI outside of the Hospital unless required by law, pursuant to a court order or patient authorization, or for treatment, payment, or health care operations purposes as defined and limited by HIPAA. There is no exception for family members except for residents of a nursing home. The North Carolina physician-patient privilege statute, N.C.G.S. § 8-53, and HIPAA allow verbal authorization or consent for release, respectively, of information to family members. However, the better practice is to document the patient's consent in order to have clear evidence of the patient's intent. The package does not include a consent or authorization to release PHI to other providers or to insurance companies or others since most providers already have such forms. The contents of this form can be combined with such existing consent forms.

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Medical History Form

Patient's Name _____ **Date of Birth**: _____–_____–_____
MM DD YYYY

Completed By: [❍ patient ❍ representative/guardian name: _____] *on* Date: _____–_____–_____
MM DD YYYY

What is the primary reason for your visit today? _____

_____

List current medication(s) you are taking, if any (including any over-the-counter medication):

Medication (Name)	Dosage (mg)	Frequency (how often?)

Please list any drug sensitivities or allergies, including the type of reaction:

Drug Name	Sensitivity or Allergy	Type of Reaction

Please select which of the following you are allergic to, if any:

[❍ Latex ❍ Rubber ❍ IV Dye ❍ Eggs ❍ Soybeans ❍ Peanuts ❍ Shellfish ❍ Other: _____]

Please list any surgeries or hospitalizations (begin with most recent).
Please include (if known) the responsible MD's name and the hospital name/location.

Month & Year	Type of Surgery/Reason for Hospitalization	MD Name	Hospital Name/Location

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Please detail any past or present medical problems that are important for your provider to be aware of, if any.

1. _____
2. _____
3. _____
4. _____
5. _____

Have you had any of the following medical problems (if not mentioned above)?
Please use your INITIALS to fill the box for yes or no. Do not use a check mark or other indication.

	YES	NO		YES	NO
Asthma or Lung Disease			Thyroid Disease		
Ulcer or Intestinal Disorder			Blood or Bleeding Disorder		
Tuberculosis (or TB Contact)			Bone, Joint, or Muscle Disorder		
Diabetes or Metabolic Disease			Communicable Disease (includes HIV)		
Hepatitis, Cirrhosis or Liver Disease			Epilepsy, Stroke, or Brain Disorder		
High Blood Pressure			Depression or Nervous Disorder		
Angina or Heart Disease			Cancer		
Blood Vessel Disorder					

Social History *All of your medical information, including this section, is kept strictly confidential.*

Smoking: [❍ never smoked ❍ former smoker ❍ current smoker]
If current smoker, how many a day? _____

Alcohol Intake: [❍ none ❍ occasional ❍ moderate ❍ heavy]

Caffeine Intake: [❍ none ❍ occasional ❍ moderate ❍ heavy]

Illegal Drugs [❍ none ❍ occasional ❍ moderate ❍ heavy]
If yes, what type and amount? _____

When was your most recent:

Complete Physical: _____ Chest X-Ray: _____ Tetanus Vaccine: _____
Colonoscopy: _____ Pneumonia Vaccine: _____ EKG Stress Test: _____
Bone Density Scan: _____ Influenza Vaccine: _____

GYN History *(Females ONLY)*

Date of last menstrual cycle: _____ [❍ regular ❍ irregular] Age of 1st menstruation: _____
If menopause, age of menopause: _____ Number of pregnancies: _____ Number of living children: _____
Any abortions/miscarriages: _____ Last pap smear date: _____ Last mammogram: _____ Other:
_____

Prostate History *(Males ONLY)*

Last prostate exam date: _____ [❍ normal ❍ abnormal]

Family History *(this is NOT your individual history – check if any of your BLOOD RELATIVES, i.e. mother, father, brothers, sisters, paternal/maternal grandparents, or your children have any of the following diseases)*

❍ Heart Disease	Who: _____	❍ High Blood Pressure	Who: _____
❍ Stroke	Who: _____	❍ Diabetes	Who: _____
❍ Blood Vessel Disorder	Who: _____	❍ Mental Illness	Who: _____
❍ Cancer	Who: _____	❍ Alcoholism	Who: _____
❍ Thyroid Disease	Who: _____	❍ Other	Who: _____

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Our Policies On Specialty Referrals And Specific Tests

There may be times when you are referred to a specialty physician(s) or a specific test(s) is ordered for you. These test/referrals will be considered to be medically necessary, and in the best interest of your health.

If you are referred to a specialty physician(s), the referred physician(s) will be handling the condition(s) that you are referred to them for. Therefore:

1. It is your responsibility to keep up with any follow-up appointments that are considered to be medically necessary by the referred physician(s), and to reschedule any missed appointments with them as soon as possible.
2. It is your responsibility to understand your condition and treatment, and you should be sure to ask your specialty physician(s) any questions pertaining to the condition you are being treated for. If your specialty physician(s) feels that they need to discuss any medically urgent or otherwise important aspect of your condition/treatment with your provider at Allmed, they should contact Allmed as soon as possible. The Allmed Clinic practice and staff are not responsible to follow up with the specialty clinic for the recommendations and follow-up services that they provide you, and our staff is not responsible for any specialty physician(s) that you are referred to.
3. Refusal of any referral and/or refusal to follow up with your referred physician(s) will be solely at YOUR OWN risk.

If you are scheduled for a specific test, (i.e. MRI, CT, X-Ray, etc):

1. It is YOUR responsibility to keep your scheduled appointment and to have the test done. If you miss your testing appointment, it is YOUR responsibility to reschedule the appointment as soon as possible.
2. Certain testing may require prior approval through your insurance company. If your insurance company denies any test, it is YOUR responsibility to contact them to discuss the denial.
3. Refusal to have any test done or failure to keep your scheduled appointment(s) is solely YOUR OWN risk.

I _____ (print name), certify that I have received a copy of these policies and that I have read and understand the policies listed above pertaining to referrals/test and also understand that any refusal of referrals/test/and/or refusal to follow up with referred physicians is solely my own decision and at my own risk.

_____ _____
PATIENT/REPRESENTATIVE SIGNATURE **DATE**

Medical Records Release Authorization

I hereby authorize Allmed Clinic, PA, to obtain and release any information needed or obtained in the course of my treatment to other providers who may be involved in my treatment. I also hereby authorize my provider to release any information in the course of my treatment to process insurance claims.

_____ _____
PATIENT/REPRESENTATIVE SIGNATURE **DATE**

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Binding Arbitration As An Alternative To Civil Litigation

In accordance with the terms of the United States Arbitration Act, I agree that any dispute arising out of or related to the provision of health care services to me by any Allmed Clinic, PA, provider, or employees, physician members, and agents, shall be subject to final binding and resolution exclusively through Health Care Claim Settlement Procedures of the American Arbitration Association. The following link can be followed in order to review a copy of the manual:

https://www.adr.org/sites/default/files/document_repository/Commercial_Healthcare_Payor_Provider_Arbitration_Rules.pdf

I understand that this agreement includes all healthcare services which previously have been or will in the future be provided to me, and that this agreement is not restricted to those healthcare services rendered in connection with any particular treatment, office visit, or hospital admission. I understand that this agreement is also binding on any individual or entity claiming by or through my behalf. I understand that this agreement is voluntary and also a precondition to receiving healthcare services. If the individual signing this agreement is doing so on behalf of his or her minor child, or any other person for whom the signer is legally responsible, then the signature bellows affirms that the signer has services so that the minor child or other person, and that his or her execution or this agreement is in furtherance of that authority or obligation.

_____ _____
PATIENT/REPRESENTATIVE SIGNATURE **DATE**

Loss of Insurance/Uninsured Patients

If you should have a lapse in insurance coverage or loss of insurance WE *DO* ACCEPT NON-INSURED PATIENTS, with the following guidelines:

- Your bill must be paid in FULL at the time of your visit or your appointment will be rescheduled.
- Your first appointment will be $100.00 due at the time of visit
- All following visits will be $85.00
- If you are admitted into the hospital you will not be able to get coverage by a provider from Allmed Clinic, PA, but will instead receive care from the hospital doctors.

I _____ (print name), understand and agree to the above guidelines.

_____ _____
PATIENT/REPRESENTATIVE SIGNATURE **DATE**

Authorization to Pay Benefits to Provider

I hereby authorize payment directly to the provider of surgical and medical benefits, if any, otherwise payable to me for this service as described including Medicare Benefits. I understand that any balance on my account is due and payable by me, including any services rendered and not covered by my insurance carrier.

_____ _____
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Consent for Treatment

The undersigned hereby consents to medical services as may be deemed necessary by the Medical Providers at Allmed Clinic, PA. The undersigned consents that Allmed Clinic, PA, may obtain and use information from other healthcare providers such as pharmacies and hospitals.

_____	_____
PATIENT/REPRESENTATIVE SIGNATURE	**DATE**

Office Policies

In order to provide you with the best care possible, we are providing you with our office policies on this page and the next page, and ask that you read and understand that these policies. If you have any questions, please do not hesitate to ask.

1. Please bring all medications with you for each and every appointment; this is necessary for the provider to properly evaluate you and make any necessary adjustments.

2. Late arrivals: It is imperative that you honor your scheduled appointment. If you are 15 minutes late, we will reschedule your appointment if we are unable to fit you into another appointment slot.

3. It is at your own risk if you allow your medications to run out before you come into the office to request your refills. Please try to avoid this type of situation from developing.

Medication refills: If you have missed your routine follow-up appointment as scheduled, you will need to come in to see the provider for your follow-up in order to get your refills.

For all other refills: If you need refills and have had your routine follow-up appointments as scheduled, you must call the office to request your refills at least 7 days prior to running out of your medication.

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I _____ (print name), have read and understood the above, and I have received a copy of the Allmed Clinic, PA, office policies.

_____ _____

PATIENT/REPRESENTATIVE SIGNATURE **DATE**

Allmed Clinic, PA Office Policies Detailed (please take this home)

In order to better serve your needs and clarify any questions that you may have regarding your insurance, appointments, prescription refills, etc., we have adopted the following policies. Please take this information home with you to refer back to. If you have any questions, please speak with a member of the office staff and they will gladly assist you.

1. Insurance filing and balance due:

- We will gladly file your insurance claim.
- If we do not participate with your insurance company, you will be responsible for payment in full the day of your appointment. We will then courtesy file your insurance claim for you and any reimbursement will be sent to you.
- Co-payments are collected when you check-in. If you are unable to pay your copay we can reschedule your appointment.
- Medicaid patients must show their Medicaid card each visit. If you do not have your new card you will be asked to reschedule your appointment.

- All insurance changes must be given to us at the time of service. If your insurance changes, and we are not notified, you will be responsible for all charges until we are notified of the insurance change. We will not be able to bill your insurance for any charges made before we are notified of an insurance change.
- In the event your health insurance plan determines a service is not covered, you will be responsible for the charge.
- As a courtesy to you, insurance forms for services rendered will be completed by our office with your primary and secondary insurance carrier. We will not file third insurance, but will provide you with the information needed to do so yourself.

2. Statement Procedure:

- We will mail a statement to the address you have provided once we receive payment from your insurance carrier. In the event that payment is not received from you within 30 days, a second past-due statement will be mailed.

3. Returned Check Fee:

- If your check is dishonored or returned for any reason, we will charge you an additional processing fee of $30.00.

4. Prescription Refills:

- If you are in need of a refill of a controlled substance, you must schedule an office visit so that the provider can evaluate you and send in the request.
- For other prescriptions, please ask your preferred pharmacy to fax us a refill request at (919) 781-8782, and allow 24-48 hours for all prescription requests to be fulfilled.
- Please bring all medications with you to each visit.

5. Completion of Forms:

- For any type of forms brought to us for staff/providers to fill out for the patient, especially those that ask for extensive information, please allow 48 hours for completion.

6. Appointment cancellations or reschedules:

- We ask that you give us 24 hours' notice if you need to cancel or reschedule an appointment. This will allow us to give the appointment to someone else who may need it.

7. Late appointments:

- If you are 15 minutes late or later for your scheduled appointment, you may be asked to reschedule.