CarolinaClinic
FOR HEALTH & WELLNESS

2459 Emerald Place, Ste. 102, Greenville, NC 27834 | P: 252.757.3939 | F: 252.757.3973 | www.carolina-clinic.com

Welcome and thank you for choosing Carolina Clinic for Health and Wellness (CCHW) as your comprehensive healthcare provider. We look forward to establishing a relationship that will meet your healthcare needs. To ensure timely care, we have outlined our policies for your review.

We have two locations to better serve you. Our Greenville office is located at 2459 Emerald Place, Suite 102, Greenville, NC 27834. Our Williamston office is located at 802 Park Street, Williamston, NC 27892. Most testing/procedures will be performed in our Greenville office. Some testing must be done at a hospital or outpatient testing center.

We ask that you bring your most recent insurance cards and all of your prescription medications, including over the counter medications to each appointment. If you fail to bring your medications or a complete list of your medications, your visit may be rescheduled. If you are more than 15 minutes late for your appointment, your appointment may be rescheduled. If there is any change in your insurance please let us know as this could affect your out-of-pocket cost.

If you are unable to keep your appointment for your office visit or testing, please call our office at least 24 hours in advance to reschedule. If you fail to contact us 24 hours prior to your visit, a $75 cancellation fee (fees vary based on the services scheduled) may be added to your account. A list of fees can be obtained upon request. These fees are not covered by insurance.

We will be happy to provide prescription refills for the medications prescribed by CCHW providers during your office visit. If you need refills before your next visit, please allow 24 to 48 hours for the nurse to call the prescription in to the pharmacy. We do not do refills on weekends or after hours.

If we refer you to another physician we will send your medical records at no charge. If you request a copy of your records, there is a minimum fee of $10 (fee depends upon the number of pages we have to copy) and you must sign a release form and pay the fee prior to getting your medical records.

We accept Medicare and most commercial insurances. Your insurance may pay all, some or none of your bill. Any remaining balance, deductible and co-payments are your responsibility. You are expected to pay your co-payment and outstanding balance at the time of your visit. If you are unable to pay your co-payment, your appointment may be rescheduled.

Your health is our number one priority.

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Please complete this form to the best of your ability. If you require assistance, please notify the front desk and a patient advocate will be made available.

First Name: _____ **Last Name:** _____ **MI:** _____

DOB: _____ **Race:** _____ **Sex:** _____

Referred By: _____ **Primary Care Physician:** _____

Reason for Today's Visit: _____

_____

How did you hear about us? _____

REVIEW OF SYSTEM (check ALL that apply)

Cardiovascular	Gynecology	GI	Psychology
___ High Blood Pressure	___ Uterine Fibroids	___ GERD/Reflux	___ Depression
___ Heart Attack	___ Ovarian Cysts	___ IBS	___ Anxiety
___ Irregular Heart Beat	___ Endometriosis	___ Ulcer	___ Bipolar Disorder
___ Heart Murmur	___ Infertility	___ Colon Polyps	___ PTSD
___ High Cholesterol	___ Chronic Pelvic Pain	___ Diverticulitis	___ ADD/ADHD
___ Blood Clots	___ Abnormal PAP	___ Liver Disease	
___ Phlebitis	___ Chronic Vaginal Infect.	___ Cancer	
___ Heart Disease	___ Cancer		

Endocrinology	Urology	Neurology	Pulmonary/ENT
___ Thyroid Disease	___ Blood in Urine	___ Migraine headaches	___ Asthma
___ Goiter	___ Loss of Urine	___ Stroke	___ Chronic Allergies
___ Diabetes	___ Bladder or Kidney (abn)	___ Seizure Disorder	___ COPD
___ Cancer	___ Chronic Renal Disease	___ Chronic headaches	___ Chronic Sinus Infect.
	___ Frequent UTI's	___ Cancer	___ Sleep Apnea
	___ Cancer		___ Lung Disease/Cancer

Dermatology	
___ Skin Cancer	Please list any additional concerns: _____
___ Psoriasis	_____
___ Acne	_____
___ Eczema	

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PAST MEDICAL HISTORY

List all significant illnesses: _____

_____

List previous hospitalizations: _____

_____

_____

List previous surgeries/serious injuries: _____

_____

_____

MEDICATIONS

Include name, dosage and over the counter supplements (attach additional page if necessary)

Medication	Dosage

ALLERGIES

(Include name of medication, reaction and severity)

Allergen (Latex, Food, Penicillin, etc)	**Reaction**	**Severity**

HEALTHCARE MAINTENANCE

List date of last exam for the following test(s)

Chest XRay:		Colonoscopy:	
Mammogram:		Lab work:	
Pap Smear/Pelvic Exam (female):		Bone Density Test:	
PSA/Prostate Exam (male):		Tetanus Vaccination:	
Shingles Vaccination:		Pneumonia Vaccination:	

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SOCIAL HISTORY	
Alcohol Use	[ ] Never [ ] Rarely [ ] Socially [ ] Moderately _____# of daily drinks
Do you smoke cigars/cigarettes or use tobacco products?	[ ] Never [ ] Current; _____# ppd [ ] Past ; Year Quit _____ Type of tobacco used/using: _____
Do you use recreational drugs?	[ ] Never [ ] Current; How Often: _____ [ ] Past ; Year Quit_____ Type of drug(s) used/using: _____
Do you exercise regularly?	[ ] Never [ ] Rarely [ ] Moderately What type of exercise? How Often? _____
Marital Status	[ ]Single [ ]Married; ___# of yrs [ ] Divorced [ ] Widowed [ ] Separated
Employment Status	[ ] Currently Employed as: _____ [ ] Unemployed [ ] Retired [ ] Disabled

FAMILY HISTORY			
Relation	**Age**	**Living/Deceased**	**Medical Issues**
Father			
Mother			
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			
Brother(s)			
Sister(s)			
Child(ren)			
Additional comments: _____			

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Patient Information

Date: _____ *(Please print)*

Patient Name: _____
(Last) *(First)* *(Middle)*

Sex: M F Date of Birth: _____ SSN: _____

Address: _____
(Street) *(City)* *(State)* *(Zip)*

Home Phone: _____ Cell Phone:_____ Work Phone:_____

Email: _____ Contact Preference: _____

Marital Status: S M D W Employer: _____ Phone: _____

Preferred Pharmacy: _____ Preferred Lab: _____

Primary Care Provider: _____

Emergency Contact Information

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Guarantor/Responsible Party Information

Responsible Party Name: _____
(Last) *(First)* *(Middle)*

Relationship to Patient: _____

Sex: M F Date of Birth: _____ SSN: _____

Address: _____
(Street) *City)* *(State)* *(Zip)*

Home Phone: _____ Cell Phone:_____ Work Phone:_____

Email: _____ Contact Preference: _____

Marital Status: S M D W Employer: _____ Phone: _____

I certify that the above information is correct and I consent to treatment necessary for the care of the above-named patient.

X_____Date: _____
Signature of patient or person acting on patient's behalf

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Health Insurance Information

Primary Insurance Policy

Insurance Company: _____ Subscriber ID: _____

Policyholder Name: _____ Group #: _____

Policyholder DOB: _____ Policyholder SSN: _____

Policyholder Employer: _____ Relationship to Patient: _____

Secondary Insurance Policy

Insurance Company: _____ Subscriber ID: _____

Policyholder Name: _____ Group #: _____

Policyholder DOB: _____ Policyholder SSN: _____

Policyholder Employer: _____ Relationship to Patient: _____

**Please provide insurance card(s) so we can make a copy for your chart

Workers Compensation

Date of Accident: _____/_____/_____ Policy/Claim ID: _____

Auth/Pre-Cert#: _____ SSN: _____

Carrier's Name: _____ Phone: _____

Address: _____ State: _____ Zip: _____

Contact Person/Attorney Name: _____ Phone: _____

Address: _____ State: _____ Zip: _____

I authorize the release of any medical information necessary to process the insurance claims.
I authorize the direct payment of benefits to the doctor rendering services.
I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health care plan.

Signature: _____ Date: _____

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FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to providing you with quality care. As part of our services, we try to contain the ever-rising cost of health care. In an effort to do this, we have implemented the financial policy listed below.

Co-Payments and Co-Insurance/Deductibles
>Your insurance requires you to pay your co-pay or co-insurance at each visit. We will collect your co-pay when you check in with the front desk.
>Our office accepts cash, credit/debit cards, health savings account cards and checks for payment.
>It is your responsibility to notify the office of any changes to your insurance.
>In the event you do not have your co-pay, you will not be seen.

Outstanding Balances
>If you have an outstanding balance, you will be asked to sign a financial agreement. This agreement will require you to provide the office with a valid credit card, debit card or e-check to be run either the 1st or 15th of each month to get your account current.

Late Cancellations/No Shows
>The office reserves the right to charge for late cancellations (appointments cancelled within 24 hours of the scheduled appointment time) and no shows.
>**Routine office visits will be charged a $75 no show fee**. The fee varies based on the services scheduled. A list of the fees can be obtained from the front desk staff.
>The office will document recurring late cancellations and no show appointments, and you may be discharged from the practice following a 30-day notice.

Collection Procedures
>Account balances must be paid in full within 90 days from the date of service. Failure to comply will result in collection actions to a collection agency or a judgment. Court filing fees ($50) will be added to your account balance.
>If your address changes, please be sure to notify us. If you have an unpaid balance and we are unable to contact you by mail, we will utilize a locator service and the fee ($33) will be added to your account.

I acknowledge that I have read this Financial Policy and agree to the terms.

_____ _____
Patient (or Responsible Party) Signature Date

_____
Witness Signature

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Right To Disclose Personal Information

Patient Name: _____

Date of Birth: _____

List one or two people (trusted family and/or friend(s) who may have access to your medical information and their relationship to you.

1. _____ _____ _____
Name **Relationship** **Phone Number**

2. _____ _____ _____
Name **Relationship** **Phone Number**

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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 takes effect on September 1, 2014 and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

***Law Requires Us to*:**
1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:
1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:
1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

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FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-payer. The information on or accompanying the bill may include your medical information.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

***Facility Directory*:** Unless you notify us that you object, the following medical information about you will be placed in our facility directories: your name; you location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

***Notification*:** We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

***Disaster Relief*:** We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

***Fundraising*:** We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

***Research in Limited Circumstances*:** We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

***Funeral Director, Coroner, Medical Examiner*:** To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

***Specialized Government Functions*:** Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

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***Court Orders and Judicial and Administrative Proceedings*:** We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

***Public Health Activities*:** As required by law, we may disclose your medical information to public health or legal authorities charges with preventing or controlling disease, injury or disability, including child abuse, or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems to enable products defects or problems, to enable recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

***Victims of Abuse, Neglect, or Domestic Violence*:** We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

***Workers Compensation*:** We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

***Health Oversight Activities*:** We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations, or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

***Law Enforcement*:** Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws. (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

***Appointment Reminders*:** We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

***Alternative and Additional Medical Services*:** We may use and disclose medical information to furnish you with information about heath-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

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4. YOUR INDIVIDUAL RIGHTS

***You Have a Right to*:**

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other that photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you for each page, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. You may contact us to submit a complaint or submit requests involving any of your rights in Section 4 of this notice by writing to the following address:

Carolina Clinic for Health and Wellness
2459 Emerald Place, Suite 102
Greenville, NC 27834

We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

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Acknowledgement of Receipt of Notice of Privacy Practices

Our Notice of Privacy Practices provides information on how our practice may use or disclose your protected health information as permitted under federal and state law. A copy of our Notice of Privacy Practices can be obtained from the front desk.

_____
Print Name

_____
Signature

_____
Date

If not signed by patient, please indicate relationship to patient and patient's name:

_____
Patient Name

_____
Relationship