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.

Carolina Clinic for Health and Wellness
Health History Form

Patient Name: ________________________________  DOB: ____________

Are you currently suffering from a physical health problem?  Y  N
Do you have any chronic health problems?  Y  N
Are you presently being treated by a Physician?  Y  N

Doctor's name: ________________________________

Have you ever been seen by a Psychologist or Psychiatrist?  Y  N

Reason: ________________________________________

Have you ever been hospitalized?  Y  N

Reason/Date: ___________________________________

Do you:

Currently drink alcohol, daily or weekly?  Y  N
If yes, describe: ________________________________

Smoke cigarettes or cigars?  Y  N
If yes, how often: ________________________________

Take recreational drugs?  Y  N
If yes, describe: ________________________________

Have any adverse reactions to medications?  Y  N

Medications (list name, including prescriptions, vitamins, supplements & herbs):
_____________________________________________________________________________________
_____________________________________________________________________________________

Please check any of the following that currently apply to you:

Feeling angry/resentful ____  Distressing recollections of a traumatic event ____
Feeling impatient ____  Difficulty falling asleep/staying asleep ____
Feeling sad ____  Restlessness, nervousness, excited ____
Weight gain/loss ____  Temper outbursts or irritability ____
Pounding heart ____  Difficulty controlling impulses ____
Chronic pain ____  Memory loss/forgetfulness ____
Blackouts ____  Thoughts about suicide ____
Dizziness ____  Fatigue/low energy ____
Anxiety ____  Over/undereating ____
Panic ____

What prompted you to seek therapy? ________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________


Patient Information

Date: __________________ (Please print)

Patient Name: ________________________________________________________________________

(Sex) M F Date of Birth: ________________ SSN: ________________

Address: ____________________________________________________________________________

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: ________________________________________________________________________

Relationship to Patient: ______________________

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

Address: ____________________________________________________________________________

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
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: ____________________________________________
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
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.
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; your 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.
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 health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.
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 than 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:

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