Conner Family Health Clinic, PLLC

Welcome to our practice. Please help us serve you better by taking a few minutes to provide the following information:

Patient Information

Patient Name	Date of Birth - -	Social Security # - -	Primary Language	Sex □ Male □ Female
Address & Apt. Number		City		State & Zip
Home Phone - -	Cell Phone - -	Work Phone - -	Email Address	
Race □African American □Asian □Caucasian □Hispanic □Other	Ethnicity □ Hispanic or Latino □ Non-Hispanic or Latino	Marital Status □ Divorced □ Married □ Separated □ Single □Unknown □ Widowed		

Responsible Party Information: (if guarantor is different from patient)

Name	Relationship to Patient	Home Phone - -	Cell Phone - -
Address	Apt. #	City	State & Zip

Emergency Contact Information:

Name	Relationship to Patient	Phone Number:

Financial Responsibility and Assignment of Insurance Benefits:

I guarantee payment to Conner Family Health Clinic, PLLC of all charges for services provided to the patient. I understand that I am personally responsible for all charges not covered by insurance. I authorize payment of surgical and medical benefits which would otherwise be payable to me, to Conner Family Health Clinic for services rendered. If covered by Medicare, I certify that the information provided by me in applying for payment under Titles V, XVIII, and/or XIX or Social Security Act is correct. If the patient is a child of divorced parents, it is the policy of the clinic that the parent bringing the child in for treatment is financially responsible for that appointment, unless otherwise stated in court documents. **I also acknowledge that I have been informed of Conner Family Health Clinic's No-Show/late cancellation policy. I understand that if I fail to show for a scheduled appointment for fail to give 24 hours notice of cancellation that I may be charged a $25.00 fee.**

Consent for Healthcare and Release of Medical Information:

I voluntarily consent to healthcare treatment from the physician and staff at this clinic. I am aware that the practice of medicine is not an exact science. No guarantees have been made to me regarding the result of treatments or examination by caregivers. I consent to the use and disclosure of protected health information about me for treatment, payment, and healthcare operations. I have read this form and have had the opportunity to ask questions and my questions have been answered.

Signature of Patient or Authorized Person: _____ **Date:** _____

Signature of Insured Party or Authorized Financial Guarantor, if different from above: _____

CONNER CLINIC
COMPLETE FAMILY HEALTH CARE

Today's Date: _____

Adult Patient History Form

Name _____ **Date of Birth**_____ **Sex:** M ____ F ____

Present Complaints _____

Currents Medical Conditions _____

Preferred Pharmacy (please include address) _____

Current Medications and Dosages (including vitamins/nonprescription drugs/herbs/laxatives etc. You may attach list or write on back): _____

_____

_____

Allergies: (Medication, Foods, Pollen, Etc) _____

Past Medical History: Have you ever had the following:

- ☐ High Blood Pressure
- ☐ Heart Attack/Angina
- ☐ Heart Murmur
- ☐ Crohn's Disease
- ☐ Rheumatic Fever
- ☐ Pneumonia
- ☐ Emphysema
- ☐ Prostate Trouble
- ☐ HIV Disease
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Phlebitis
- ☐ Bleeding Disorder
- ☐ Sickle Cell Anemia
- ☐ Blood Transfusion
- ☐ Gallstones
- ☐ High Cholesterol
- ☐ Hepatitis
- ☐ Kidney Disease/Stone
- ☐ Stomach Ulcers
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Cancer
- ☐ Sexually Transmitted Disease
- ☐ Arthritis
- ☐ Stroke
- ☐ Migraine headaches
- ☐ Seizures
- ☐ Anxiety
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Depression
- ☐ Trouble achieving and/or maintaining an erection

Other Serious Illnesses/Hospitalizations/Injuries:

_____

_____

Surgical History: Please list all prior surgeries and dates:

_____

Immunizations (Please list date of last vaccination)

☐ Hepatitis A_____ ☐ Hepatitis B_____ ☐ Pneumovax (pneumonia) _____

☐ Influenza (flu) _____ ☐ Tetanus _____ ☐ Other _____

Health Maintenance Screening Tests: Please list the date and indicate if results were abnormal

Lipid (cholesterol)_____ Abnormal? ☐ Yes ☐ No

PSA(prostate) _____ Abnormal? ☐ Yes ☐ No

Colonoscopy _____ Abnormal? ☐ Yes ☐ No Dexa Scan _____ Abnormal? ☐ Yes ☐ No

Mammogram_____ Abnormal? ☐ Yes ☐ No Pap Smear_____ Abnormal? ☐ Yes ☐ No

Adult Patient History Form - Page 2

Name _____ **Date of Birth** _____

Family History:

	Age:	Alive:	Deceased:	Health Problems:
Father				
Mother				
Sister				
Brother				
Paternal Grandparents				
Maternal Grandparents				
Children				
Other:				

Habits:

	Yes	No	Amount/Type
Use Drugs (marijuana, cocaine, etc.)			
Use Tobacco: (Cigarettes, Pipe, Cigar, Snuff, Chew)			
Use Alcohol: (Beer, Wine, Liquor)			
Use Caffeine: (Coffee, Tea, Soda)			
Diet: (Restrictions, Special Diet)			
Exercise Regularly			
Wear seat belts?			
Bike Helmet			

Sexual Activity: ☐ Yes ☐ No ☐ Not Currently Current sex partner(s) are: ☐ Male ☐ Female
Birth Control Method: _____ ☐ None Needed
Have you ever had any sexually transmitted diseases (STD's)? ☐ No ☐ Yes
Are you interested in being screened for sexually transmitted diseases? ☐ No ☐ Yes

Other Concerns:
Are you satisfied with your weight? ☐ No ☐ Yes
How do you rate your diet? ☐ Good ☐ Fair ☐ Poor
Do you eat or drink four servings of diary or soy daily or take calcium supplements? ☐ No ☐ Yes
Is violence at home a concern? ☐ No ☐ Yes Have you ever been abused? ☐ No ☐ Yes
Do you have a gun in your home? ☐ No ☐ Yes
Do you have a living will or durable power of attorney for your healthcare? ☐ No ☐ Yes
Do you have a living will or advance directive? ☐ No ☐ Yes
Are you interested in information about this? ☐ No ☐ Yes

Socioeconomics: Occupation: _____ Employer: _____
Years of education/highest degree: _____ Spouse/partner's Name: _____
Number of children/ages: _____ Who lives in the home with you? _____

Women's History: # Pregnancies_____ # Deliveries ____ # Abortions ____ # Miscarriages ___
Regular Periods ☐ No ☐ Yes Age at start of periods: _____ Age at end of periods: _____
Age of Menopause: _____ Do you perform monthly self breast exams: ☐ No ☐ Yes

Authorization for Release of Information

Name of Patient _____ Date of Birth _____

Conner Family Health Clinic is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others keeping with the patient's instructions.

Where/Who we may leave information:	**Which information may we leave:**
Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
❑ Voicemail ❑ Email _____	❑ Results of lab tests/x-rays ❑ Lab Results, Appointment Correspondence, Limited Medical Information
❑ Spouse (provide name and phone number) _____	❑ Financial ❑ Medical as follows: _____
❑ Parent (provide name and phone number) _____	❑ Financial ❑ Medical as follows: _____
❑ Siblings (Over the age of 18) ❑ Other (i.e. Stepparent, Grandparent, Children over the age of 18) _____	❑ Financial ❑ Medical as follows: _____ _____

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that the information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ Date _____

Signature of Patient or Personal Representative

Revised May 2018

Conner Family Health Clinic

Acknowledgement of Receipt
Notification of Practice Privacy

Patient's Name and Address: _____

_____

_____

I have received a copy of the Notification of Practice Privacy for the practice named above.

_____ _____

Signature **Date**

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Practice Privacy because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was sent by mail at the request of the patient.
- ❑ We could not communicate with the patient for the following reason:

  _____

- ❑ Other: _____

  _____

Prepared by _____

Signature _____

Date _____

CONNER CLINIC
COMPLETE FAMILY HEALTH CARE

OFFICE POLICIES & PROCEDURES FOR PATIENTS

Effective, **Monday November 26, 2018,** Conner Family Health Clinic, will inforce the outlined Office Policies and Procedures below. **Your initials and signature**, as a valued patient of Conner Family Health Clinic, is your agreement of the following policies, terms and conditions. **Failure to comply with the following policies and procedures could result in patient discharge from Conner Family Health Clinic.**

_____ **Same Day/Next Day Appointments:** In order to better serve our patients in the best way possible, we cannot do it alone, we need your help. Your health is our priority and it should be yours as well. Conner Family Health Clinic schedules patients by appointment only and reserves space for daily same day visits on a need by need basis. In order to accommodate same day/next day visits at our office, we ask that you be mindful of your responsibilities as a patient. It is your duty to plan ahead when it comes to medication refills, follow-ups and work schedules. Same day appointments will be triaged by a nurse and forwarded to Dr. Conner for approval. **Medication refills and follow-up appointments are not considered urgent.** Calls received in the morning will be reviewed and scheduled in the afternoon if approved by Dr. Conner. Calls received in the afternoon will be scheduled the following day business day.

_____ **Scheduled appointment grace period:** Arrange to arrive 10 – 15 minutes prior to your scheduled appointment. Patients are given a 10 minute grace period to arrive to scheduled appointments. Patients who have arrived on time for their appointment will be seen ahead of those who arrive late. If you arrive late, we may need to abbreviate or reschedule your visit depending on the schedule.

_____ **"No-Show" Fee Policy:** Conner Family Health Clinic has a $25 "No-Show" Fee. A No-Show fee will be assessed and your appointment will be rescheduled if you arrive 21 minutes past your appointment time. A $25 "No-Show" fee will also be accessed for failure to communicate, cancel or reschedule within 24 hours of the scheduled appointment. After the third no-show, it will be at the physician's discretion as to whether a discharge letter will be sent out disengaging you from the practice. This means you will no longer be able to schedule appointments in our office. **No-Show fees must be paid prior to scheduling another appointment. Front office staff may exercise limited discretion in assigning "no shows" to account for special circumstances, such as hospitalization or another emergency.**

_____ **Copays and Deductibles:** We will not be able to see a patient for a scheduled appointment if you do not pay your Copay, this is non-negotiable. The contract between patient and insurance requires that each patient pay their copay at the time of service. **There is no copay for Annual Wellness Exams (physicals);** however, if you present with medical symptoms or chronic health issues that need to be addressed in conjunction with your wellness exam, we will bill your insurance company a separate office visit for those other issues. **This is offered as a convenience for you**, saving you the time of having to come in for an additional visit. This may result in a charge being passed back to you for the additional visit, in that case an invoice for your copay and visit will be mailed to you for payment. **If you have a deductible of $6,000 or more, Conner Family Health Clinic will require a $75.00 deposit prior to seeing Dr. Conner.**

_____ **Insurance Verification/Supplemental Plans:** To help expedite your visit, avoid billing errors and prevent nonpayment for services rendered at this clinic. **It is your responsibility to verify before your**

appointment with Dr. Conner that he is <u>in</u> network with your insurance carrier. WE DO NOT ACCEPT BCBS – BLUE LOCAL or MEDICAID. Patients are responsible to update their insurance information with the receptionist at check-in and provide their current insurance card(s). In the event, the patient fails to update staff on new insurance information, Conner Family Health Clinic will bill the patient for any services denied by the insurance carrier we have on file. For patients with Medicaid as a supplemental insurance used to cover the remaining balances from your primary insurance, you will be responsible for the balance not paid since we are not in network, in some cases it may be the full cost of services rendered. Failure to communicate, resolve or to pay any outstanding invoices will result in referral to collections.

_____ **Patient Balances:** Depending on the plan you have you may have a deductible. This is the amount of money you have agreed to pay **BEFORE** your insurance plan with begin to pay. After each visit we will submit your visit information to your insurance. If you have a remaining deductible, you will receive an invoice from our billing office. Our billing office will send out a maximum of 2 invoices before we send your balance to collections. You may pay balances at the time of your visit, by mail or over the phone. **Please communicate with us.** We have options available to those who need it. Patients with balances over $300 or that are in collections will not be seen unless a payment or an arrangement have been made. For additional billing inquiries please contact **JMK Billing at (980)258-8657.**

_____ **Medication Request:** It is good practice to request medications a least 1 – 2 weeks prior to running out, allowing you time to request your medications and obtaining an appointment if necessary. **Please call your pharmacy and have them request your medications via fax or electronically.** Allow 24 – 48 hours to receive medication requests. **Note:** If requests are made at the end of business, the 24 – 48 hours will begin the next business day. Medications prescribed by other providers will not be filled by Dr. Conner unless an agreement has been made between Dr. Conner and you during a visit.

_____ **Mandatory Office Visit Schedule:** Controlled substances will not be filled without a visit. FMLA forms and other forms that require questions to be answered require a patient to be seen for a visit. Work excuses/school excuses will not be given without a visit. Patients whom Dr. Conner feels are not stable may require frequent follow-ups to adjust medications and additional testing. Dr. Conner may refuse to fill certain medications if he feels a patient's health is at risk without further observation or is non-compliant.

_____ **Lab Work:** In an effort to work efficiently with our Laboratory vendors, **patients who knowingly need lab work should schedule appointments on Tuesday & Fridays between 8:30am – 12:30pm.** However, if during a scheduled visit, a patient will need lab work outside of these laboratory times, we have staff available to accommodate them during regular business hours.

_____ **Form Completion:** Any forms or specialty letters such as CMS sports physicals, work physicals, FMLA, Immigration, Disability, Counseling etc, that require completion by Dr. Conner or any of the Conner Family Health Clinic staff, may not be done the same day- unless you have an appointment. It is in your best interest to plan ahead and allow ample time to complete your request. **Note: There is a cost associated with this service and some forms may require additional information not available at the time of service.** Be prepared to pay a minimum of $35 and a maximum of $150, depending on the form.

_____ **Medical Record Request:** Medical record requests can be **faxed to 704-708-4389.** We will need a signed medical release consent form allowing us to release the patient's information to the desired facility. A turnaround time of 3-5 days is needed in order to complete certain requests. Certain fees may apply and are in accordance with North Carolinas statute § 90-411, medical record copy fees.

CONNER CLINIC
COMPLETE FAMILY HEALTH CARE

CREDIT CARD ON FILE POLICY

At Conner Family Health Clinic, we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Without this authorization, a billing fee of **$25** will be added to your account for any balances that we must attempt to collect through mailing monthly statement. Furthermore, an "outstanding balance" charge of **1.5 percent** of the total bill will charge for each month that the bill remains unpaid.

Your credit card information is kept confidential and secure and payments to your card are processed **only** after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

I authorize Conner Family Health Clinic to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

❑Amex ❑Visa ❑Mastercard ❑Discover

Credit Card Number _____

Expiration Date _____ / _____ / _____

Cardholder Name _____

Signature _____

Billing Address _____

City _____ **State**_____ **Zip** _____

I (we), the undersigned, authorize and request Conner Family Health Clinic to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by Conner Family Health Clinic.

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to Conner Family Health Clinic in writing and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____

Date: _____ / _____ / _____