SUMMIT Family Medicine Laser & Cosmetic Center

Today's Date _____ Patient Number _____ Patient Registration - 1

## Patient Information

Name _____
Last First Middle Maiden

Mailing Address _____
Street City State Zip

Physical Address _____
(if differs from above) Street City State Zip

Telephone Number (___)_____ Cell Phone Number (___)_____ Email Address _____

Date of Birth _____ Social Security Number _____
mm/dd/year

(Circle One)

Sex: Male Female Status: Minor Single Married Separated Divorced Widowed

Race: White Black Asian Alaskan Native American Indian Other _____

Hispanic Ethnicity: Yes No Primary Language _____

Employer _____ Phone Number (___)_____

Address _____
Street City State Zip

Emergency Contact: Name _____ Telephone Number (___)_____

How did you hear about us? ☐ Friend ☐ Internet ☐ Newspaper ☐ Phonebook ☐ Referral Physician ☐ Other _____

## Person Responsible for Bills (Guarantor) **Please complete this section if other than self***

Name _____
Last First Middle Maiden

Mailing Address _____
Street City State Zip

Telephone Number _____ Relationship to Patient _____

Date of Birth _____ Social Security Number _____
mm/dd/year

## Alternate Emergency Contact Information (Other than Household Member or Self)

Name _____
Last First Middle Maiden

Address _____
Street City State Zip

Telephone Number _____ Relationship to Patient _____

**Please continue on back side**

Patient Name _____ Patient DOB _____ Patient Registration-2

## Insurance Information

(1) Primary Insurance Company Name _____

Policy Holder Name (as listed on card) _____ Policy Holder Employer _____

Policy Number _____ Group Number _____

**If Policy Holder is not the Guarantor or the Patient, please complete the following:

Policy Holder Social Security Number _____ Policy Holder Date of Birth _____

Relationship of Patient to Policy Holder _____

(2) Secondary Insurance Company Name _____

Policy Holder Name (as listed on card) _____ Policy Holder Employer _____

Policy Number _____ Group Number _____

**If Policy Holder is not the Guarantor or the Patient, please complete the following:

Policy Holder Social Security Number _____ Policy Holder Date of Birth _____

Relationship of Patient to Policy Holder _____

(3) Third Insurance Company Name _____

Policy Holder Name (as listed on card) _____ Policy Holder Employer _____

Policy Number _____ Group Number _____

**If Policy Holder is not the Guarantor or the Patient, please complete the following:

Policy Holder Social Security Number _____ Policy Holder Date of Birth _____

Relationship of Patient to Policy Holder _____

# Summit Family Medicine Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have questions regarding patient and insurance responsibility for services rendered we have developed this payment policy. Please read and ask any questions you may have and sign in the space provided.

I. **Knowing your insurance benefits is your responsibility:** We participate in most insurance plans. If you are not insured by a plan we participate in full payment is due at time of service. If you are covered by a participating insurance but do not have a current insurance card, payment is due in full at time of service until we can verify your coverage. Please contact your insurance provider with any questions about your coverage.

II. **Co-payments and deductibles:** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us uphold the law by paying your co-payments or co-insurance at each visit.

III. **Non-covered services:** Please be aware that some and perhaps all of the services you receive may not be covered or considered reasonable or necessary by Medicare or your insurance provider. These services require payment in full at the time of the visit. We make every effort to perform services that should be covered, but it is not possible to guarantee coverage for each plan or know plan payment limitations. You are responsible for payment if a service is performed and is later not covered by your insurance carrier. Ultimately it is YOUR responsibility to know what is covered by your insurance plan.

IV. **Proof of Insurance:** We must obtain a copy of your driver's license and current insurance card. If you fail to provide this information you may be responsible for the balance of a claim. **Coverage Changes:** If your insurance changes please notify us before your next visit so we can update our records to help you maximize your benefits. If your insurance does not pay your bill within 90 days of your visit you will be billed the balance.

V. **Claims Submission:** We submit your claims and assist you any way we reasonably can to help get your claims paid. It is your responsibility to provide any requested information to your insurance company when they request it from you. If is ultimately your responsibility to pay your balance if insurance does not pay for any reason. Your insurance plan is a contract between you and the insurance company, Summit Family Medicine is not party to that contract.

VI. **Nonpayment:** If your account is over 90 days past due you will receive a letter stating you have 15 days to remit payment in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware if a balance remains unpaid we will refer your account to a collection agency and yourself and your family members may be discharged from the practice. If this takes place you will be notified by mail that you have 30 days to locate alternative medical care. During this 30 day period Summit Family Medicine will provide you medical care in emergency situations only.

VII. **Missed Appointments:** Our policy is to not charge for missed appointments canceled at least 24 hours before the scheduled time. Patients who repeatedly miss appointments without notifying our office adequately will be charged a $25 fee or will be dismissed from the practice. These charges are the patient's responsibility and will be billed directly to you. Please help us serve you better by keeping your scheduled appointments.

VIII. **Payment Plans:** Patients who do not have insurance coverage or who have large deductibles may be considered for a payment plan if prearranged with our billing supervisor. Payment plans are NOT allowed for copayments. As a courtesy to our patients without insurance coverage with offer discounted lab services. These lab fees must be paid to our office at your visit.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Please let us know if you have any questions or concerns regarding our payment policy.

**I have read and understand the payment policy and agree to abide by its guidelines:**

_____ _____

**Signature of patient or responsible party** **Date**

# FORMULARY BENEFITS DATA CONSENT FORM

Formulary Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

By signing below I give permission for **Summit Family Medicine** to access my pharmacy benefits data electronically through RxHub. This consent will enable **Summit Family Medicine to:**

Determine the pharmacy benefits and drug copays for a patient's health plan.

Check whether a prescribed medication is covered (in formulary) under a patient's plan.

Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications.

Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.

Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RxHub.

_____ _____

Patient Name (PRINTED) Date of Birth

_____ _____

Patient/Guardian Signature Date

# Summit Family Medicine

## HIPAA Privacy Authorization Form

***Authorization for use or disclosure of Protected Health Information***

**(Required by the Health Insurance Portability and Accountability Act)**

I authorize Summit Family Medicine to use, disclose, and discuss my protected health information to the following person and/or entities:

Please list any individual, physician, or business you would like your health information released to upon request or as needed.

_____

_____

_____

_____

This authorization does not expire unless patient provided expiration date is listed here:

_____

All health information is eligible for release upon signing this form, UNLESS specified by checking the category below:

- o Mental Health Records
- o Communicable Diseases (including HIV and AIDS)
- o Alcohol/Drug abuse treatment
- o Other: (please specify)

This medical information may be used by the person I authorize to receive this information for my medical treatment, consultation, billing or claims payment. I understand I have the right to revoke the authorization in writing at any time. I understand that revocation is not effective on any information already provided to other entities. I understand my treatment and payment will not be conditioned based on signing this document.

_____

Patient Printed Name

_____

Parent/Guardian Signature Date

Summit Family Medicine also participates in **NC HealthConnex**, a secure computer system for doctors, hospitals, and other health care providers designed to improve patient care by sharing key medical information. This provides our office with a more complete electronic medical record, enabling us to offer our patients more comprehensive care. Brochures are available in our lobby. Please feel free to speak with our staff concerning any questions you may have.

If you choose to opt out of NC HealthConnex please pick up a form at our front desk or print one from the "For Patients" section of https://hiea.nc.gov/ and mail it to the designated address. Opting out will not adversely affect your treatment and you may change your decision at any time by completing another form and checking "Rescind Opt-Out."

Patient Name_____ Today's Date_____

Age_____ Birth date_____ ☐Married ☐Single ☐Divorced ☐Widowed ☐Partnered

Reason for visit_____

**MEDICAL HISTORY:** *Please check if you have been treated for the following problems in the past*

- ☐ ADD
- ☐ Alcoholism
- ☐ Allergies/Hayfever
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Asthma
- ☐ Bronchitis, Chronic
- ☐ Cancer
- ☐ Cataracts
- ☐ Crohns disease/colitis
- ☐ Dementia
- ☐ Diabetes
- ☐ Diverticulosis
- ☐ Depression
- ☐ Emphysema/COPD
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gout
- ☐ Hypertension(High Blood Pressure)
- ☐ High Cholesterol
- ☐ Heartburn/Reflux
- ☐ Heart Disease
- ☐ Heart murmur
- ☐ Congestive Heart Failure
- ☐ Hepatitis
- ☐ Irritable Bowel Syndome
- ☐ Irregular pulse
- ☐ Kidney stones
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Fibromyalgia
- ☐
- ☐ Neuropathy
- ☐ _____
- ☐ _____
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pancreatitis
- ☐ Peripheral vascular disease
- ☐ Prostatitis
- ☐ Psoriasis
- ☐ Sleep apnea
- ☐ Seizures
- ☐ Sinus problems
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Tremors
- ☐
- ☐ Ulcers
- ☐ Varicose veins
- ☐ HIV
- ☐ _____
- ☐ _____

**SURGICAL HISTORY:**

| Year | Name of Surgery | Any complications? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**PREGNANCIES:**

| Year of birth | Sex | Any complications? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**MEDICATIONS:** *Please list all medications that you are taking including over the counter medications and herbal products:*

_____

_____

_____

_____

_____

**ALLERGIES:**

| Name of medicine or substance | What reaction did you have? |
|---|---|
| | |
| | |
| | |
| | |
| | |

**VACCINES/TESTS:** Year of last

Tetanus vaccination: _____

Pneumovax: _____

Flu vaccination: _____

Pap test: _____

Mammogram: _____

Colonoscopy: _____

Sigmoidoscopy: _____

Prostate exam: _____

PSA test: _____

Cholesterol test: _____

**FAMILY HISTORY:**

| Relation | Age | State of Health | Age at Death | Cause of death | Medical conditions |
|---|---|---|---|---|---|
| Father | | | | | |
| Mother | | | | | |
| Brothers | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| Sisters | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| Maternal Grandfather | | | | | |
| Maternal Grandmother | | | | | |
| Paternal Grandfather | | | | | |
| Paternal Grandmother | | | | | |

**HEALTH HABITS:**

Caffeine: ☐ Y ☐ N Servings per day _____

Alcohol: ☐ Y ☐ N Drinks per day _____ Drinks per week _____ Drinks per month _____

Tobacco: ☐ Y ☐ N Pack(s) per day _____ Prior smoker??-quit date _____

Chewing tobacco: ☐ Y ☐ N Cans per day _____ Cans per week _____

Marijuana: _____ Cocaine: _____ Other street drugs: _____

Sexually active: ☐ Y ☐ N Condom use: ☐ Y ☐ N

Exercise: Type:_____ Frequency: _____ days per week, _____ days per month

Occupation: _____

*To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.*

_____ _____
Signature of patient, parent, guardian Date

_____ _____
Name of patient, parent, guardian Relationship to Patient

_____ _____
Reviewed by Date