Progressive Medical Associates, PLLC

PATIENT REGISTRATION INFORMATION

(PLEASE PRINT)

PATIENT NAME: _____ ❑ M ❑ F
(Last) *(First)* *(Middle)*

ADDRESS: _____CITY: _____ STATE: ____ ZIP _____

BIRTHDATE: ___/_____/_____ SSN: _____ EMAIL ADDRESS: _____

CELL PHONE: _____ HOME PHONE: _____

MARITAL STATUS: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widow PREFERRED LANGUAGE: _____

RACE: ❑ White ❑ Black or African American ❑ Asian ❑ American Indian or Alaskan Native
❑ Native Hawaiian or Pacific Islander ❑ White Hispanic or Latino ❑ Black Hispanic or Latino

EMERGENCY CONTACT PERSON _____ RELATIONSHIP _____

ADDRESS: _____ TELEPHONE: _____

PREFERRED LOCAL PHARMACY: _____ Address: _____

MAIL ORDER PHARMACY: (If you have one): _____

PRIMARY INSURANCE _____ NAME OF POLICY HOLDER _____
INSURED'S ID # _____GROUP # _____ BIRTHDATE OF POLICYHOLDER: _____
SECONDARY INSURANCE _____ NAME OF POLICY HOLDER _____
INSURED'S ID # _____ GROUP # _____ BIRTHDATE OF POLICYHOLDER: _____

WILL THE PATIENT BE THE FINANCIALLY RESPONSIBLE PARTY: ❑Yes ❑No

IF NO, WHO WILL BE THE FINANCIALLY RESPONSIBLE PARTY? _____

RELATIONSHIP TO PATIENT: _____ SSN # :_____ PHONE_____

ADDRESS _____

NOTICE OF PRIVACY PRACTICES:

❑ You were provided with a document entitled "Notice of Privacy Practices." It is required that all medical facilities provide you with this notice. Please check the box to acknowledge that you have read (or had the opportunity to read if you choose) and understand the notice. This is a copy of the notice that is yours to keep. If you do not want the copy, you may return it to the receptionist.

INSURANCE INFORMATION & OFFICE POLICIES:

❑ Please check the box to acknowledge that you have been given a copy of our insurance information & office policies.

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I understand my insurance coverage is a relationship between my insurance company and myself, and I agree to accept financial responsibility for charges incurred that are not reimbursed by my insurance company. I understand that I may be billed for "no-shows" or late cancellations.

PRINTED NAME of PATIENT: _____ DATE: _____

SIGNATURE (Patient or financially responsible party): _____

(If patient is under the age of 18, must be signed by financially responsible party)

Progressive Medical Associates, PLLC

NEW PATIENT HEALTH QUESTIONNAIRE

Room: ____

NAME: _____ DATE: _____

What is the reason for your visit today? _____

Please list any current or past medical problems along with the approximate year they occurred: _____

_____

_____

_____

Please list any hospitalizations and the year they occurred, including surgeries: _____

_____

_____

_____

Please list any other physicians you are currently seeing:

Physician ***Location*** ***Reason***

_____

_____

_____

MEDICATIONS: Please list the medications you are taking (including over-the-counter, vitamins, herbs & birth control):

Medication ***Dosage*** ***How often you take it***

ALLERGIES: Do you have any allergies to any medications? ❑Yes ❑No

Medication ***Reaction***

FAMILY HISTORY:

	Living	Deceased	Medical conditions and the age that they occurred
Father	____	____	_____
Mother	____	____	_____
Siblings	____	____	_____
	____	____	_____
	____	____	_____
	____	____	_____

Is there anyone else in the family that has suffered from high blood pressure, diabetes, high cholesterol, heart disease, prostate cancer, breast cancer, colon cancer or anything else you feel is important? _____

_____

_____

SOCIAL HISTORY:

Occupation: _____ Highest Level of Education/Degree_____
Marital Status: _____Spouse's occupation?_____ Highest Level of Education/Degree _____
# of children & ages: _____Who lives at home with you? _____
Are you currently a smoker? ❑Yes ❑No If yes, how much do you smoke daily? _____
If you do not currently smoke, have you ever been a cigarette, pipe, or cigar smoker? ❑Yes ❑No
If yes, how many packs/day did you smoke? _____ How many years did you smoke? _____ Year Quit _____
Any exposure to secondhand smoke (others smoking around you) either currently or in the past? ❑Yes ❑No
If yes, please explain: _____
How much alcohol do you drink? Per Day _____ Per Week _____ Per Month _____
Have you or anyone else ever worried about your use of alcohol? ❑Yes ❑No
Do you currently use recreational drugs (like marijuana, etc)? ❑Yes ❑No
Do you wear a seatbelt? ❑Yes ❑No ❑Occasionally
Do you exercise regularly? ❑Yes ❑No
If yes, what do you do for exercise and how often? _____
Please describe your diet? _____
What do you and your partner use for contraception (*if applicable*): _____
Do you have any risks factors for STDs such as IV drug use, blood transfusions, multiple sexual partners? ❑Yes ❑No

HEALTHCARE WISHES: Is there anything I should know about your healthcare wishes*? (for instance, you already have a healthcare proxy or a living will; you are an organ donor, etc.)* _____
_____

Do you agree with the following statement? ❑Yes ❑No ❑Not Sure

If I had a readily reversible condition like a bad pneumonia, I would want to be placed on life support temporarily; however, I would not wish to remain on life support if I had no chance for a quality of life.

If you were unable to make your own healthcare decisions *(for instance, you were in a coma from a car accident),* whom would you like us to ask about what your wishes would be? Please name one person and one alternate. You can also fill out a healthcare proxy form.

Name: _____Phone No: _____Relationship to You: _____
Name: _____Phone No: _____Relationship to You: _____

HEALTH MAINTENANCE:

Have you ever had:	***Yes***	***No***	***If Yes, date of last***
Physical Exam	___	___	_____
Cholesterol Checked	___	___	_____
Colonoscopy/Sigmoidoscopy	___	___	_____
Flu Shot	___	___	_____
Pneumonia Shot	___	___	_____
Tetanus Shot	___	___	_____
MMR Shot (*Measles/Mumps/Rubella)*	___	___	_____
Hepatitis Shot	___	___	_____
Skin Test for TB (*PPD*)	___	___	_____

Female Patients:	***Yes***	***No***	***Date of Last***
Physician Breast Exam	___	___	_____
Pap Smear	___	___	_____
Mammogram	___	___	_____

Male Patients:	***Yes***	***No***	***Date of Last***
Prostate Exam	___	___	_____
PSA Blood Test	___	___	_____
Testicular Exam	___	___	_____

Progressive Medical Associates, PLLC
13220 Rosedale Hill Avenue
Huntersville, NC 28078
Phone: 704-766-0320 Fax: 704-766-0407

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient: _____ D.O.B. _____

Social Security Number: _____

I hereby request that my Medical Records be released to: Progressive Medical Associates, PLLC
13220 Rosedale Hill Avenue
Huntersville, NC 28078

Information to be disclosed:

□Complete Medical Records
□Progress Notes
□Diagnostic Records Pertaining to _____
□Lab Results
□X-ray Reports
□Hospital Records of Admission on _____
□ Other: _____

I understand that I have the right to revoke this authorization at any time by sending a written notification to Progressive Medical Associates. I understand that a revocation is not effective in cases where the information has already been disclosed, but will be effective immediately upon receipt of written notification by this Practice. I understand that 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 by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditional on signing this authorization. This authorization shall be in force and effect until revoked by the patient or representatives signing the authorization.

_____ _____
Signature of Patient or Representative Date

_____ _____
Print Name of Patient (or Representative) Relationship of Representative to Patient
(if signed by someone other than the patient)

Progressive Medical Associates, PLLC

Authorization for Release of Information to Family and/or Friends

Name of Patient:_____**Date of Birth:**_____

I authorize Progressive Medical Associates to release protected health information to the entities named below:

Give information to spouse/partner: Yes No N/A

Name of spouse/partner: _____

Give information to the following family members or friends:

Name	***Relationship***	***Phone Number***

Description of Information to be released to family or friend:

Financial/Billing: Yes No

Medical Information: Yes No

Please list any restrictions regarding information to be released:_____

_____

I understand that I have the right to revoke this authorization at any time by sending a written notification to Progressive Medical Associates. I understand that a revocation is not effective in cases where the information has already been disclosed, but will be effective immediately upon receipt of written notification by this Practice. I understand that 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 by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditional on signing this authorization. This authorization shall be in force and effect until revoked by the patient or representatives signing the authorization.

_____ _____

Signature of Patient or Representative Date

_____ _____

Print Name of Patient (or Representative) Relationship of Representative to Patient (*if signed by someone other than the patient)*

PROGRESSIVE MEDICAL ASSOCIATES, PLLC
13220 Rosedale Hill Avenue
Huntersville, NC 28078
Phone: 704-766-0320 Fax: 704-766-0407

ADVANCE BENEFICIARY NOTICE

In certain cases, your provider, based on his or her medical opinion, may request that a service and/or test be performed that may not be considered a covered service or may not be deemed "medically necessary" as defined by your insurance plan.

Also, keep in mind that sometimes a service is "covered", but is applied toward a yearly deductible (or you may be responsible for some percentage of co-insurance).

Due to the vast number of insurance plans with varied coverage policies, we cannot determine with absolute certainty the specifics of your particular plan. We will do our best to answer any questions you may have, but *if you need confirmation of coverage or whether a service will be subject to co-insurance or deductible, we encourage you to contact your insurance company directly prior to receiving the service.*

PHYSICALS / WELLNESS VISITS:
Most patients are now eligible for an annual "wellness" visit at no cost to the patient (no co-pay, no co-insurance, and no deductible). We would like to clarify some common misunderstandings regarding this benefit:

1) Please be aware that this "no cost" coverage only pertains to services that are "preventative" in nature and does not necessarily apply to any service your provider orders. *If you come in for a wellness visit and your provider orders labs and/or other tests, some of these services may not fall under the "wellness" benefit and may be subject to co-insurance and or deductible.*

2) If you have new symptoms or other medical conditions that need to be addressed, this service does not fall under your wellness benefit, and you will either need to make a separate appointment or, if addressed during the same appointment, this service will be billed *in addition* to the wellness visit, which may result in a co-pay, co-insurance, and/or deductible.

3) Please make sure that you are following any annual limits that your plan imposes (for example, does your plan cover one "wellness" visit per calendar year or one within any 12-month period?). If you have already used your "wellness" benefit, your insurance company will deny the claim, and payment will be your responsibility. We are not able to verify this information with every patient's policy. In addition, we do not know if you have had a wellness visit with another provider. We can only tell you the date that we last billed a wellness visit for you.

NUMBER TO LEAVE PRIVATE MEDICAL MESSAGES:
May we leave voice mail messages for you that may contain private medical information such as lab or test results, medications, etc?

❑ YES, I agree to receive private medical messages at the following phone number: _____
❑ NO, do not leave voice mail messages containing private medical information.

By my signature below (or the signature of my representative), I agree that I have read and understand the above notification and that I accept financial responsibility for any services not covered by my insurance carrier or services that my insurance carrier deems "patient responsibility."

_____ _____
PRINTED NAME OF PATIENT **DATE**

_____ _____
SIGNATURE OF PATIENT ***(or financially responsible party)*** **PRINTED NAME OF REPRESENTATIVE**
(If signed by someone other than patient)