Orchard Health Centers, PLLC.
702 13th Street
North Wilkesboro, NC 28659
(336) 990-9540

Thank you for considering Orchard Health Centers, PLLC (OH) for your health and wellness needs!

How to Become a Patient of OH

All patients seeking entry into the practice are pre-screened based on the prospective patient's self-reported health history, information obtained from available North Carolina databases and metrics used to ensure the baseline health information falls within the scope of practice of our clinical team. ***Incomplete or unsigned applications will not be processed for acceptance.***

Reasons for denial of acceptance may or may not be disclosed to the applicant. Reasons for denial can include high-level medical complexity, multiple prescribing providers, failure to disclose the use of controlled prescription medications, history of controlled substance medication use, recommendation of OH Patient Compliance Panel, history of medical non-compliance, or a history of illegal activities.
If the new patient application is for an individual under the age of 18, the minor patient's parent or legal guardian is required to be present at every visit to OH.

Demographic Information:

Full Legal Name:_____ Age:_____

Date of Birth:_____ Social Security #:_____ Male / Female

Phone #:_____ Email Address:_____

By providing your phone number and email address, you agree to receive appointment reminders and other necessary communications.

Mailing Address:_____

_____

Height:_____ Weight:_____ Marital Status: Single Married Divorced Engaged Separated Widow/Widower

Race: White Black Asian Hispanic American Indian

Sexual Orientation: Straight/Heterosexual Gay/Lesbian/Homosexual Bisexual Other:_____

Are you currently sexually active? Yes / No Current Contraceptive Method:_____

Preferred Pharmacy:_____

Current/Recent Primary Care Provider:_____

How did you hear about Orchard Health?_____ If referred, by whom? _____

Insurance Company:_____ Insurance ID #:_____ Group #: _____

Effective Date:_____ Insurance Policy Holder:_____ Policy Holder SSN: _____

Policy Holder DOB:_____ Policy Holder Phone #: _____ Relation to Patient: _____

Guarantor (person responsible for bill or parent if different from patient): _____

Relationship to patient: Self Spouse Parent Phone #:_____ Date of Birth: _____

Address: _____

Social Security #:_____ Employer:_____

Do you have or have you had and of the following: Please check all that apply

	High Blood Pressure		High Cholesterol		Fibromyalgia		Schizophrenia		Cancer Type:
	Diabetes		Asthma		Lupus		Chronic Back Pain		
	Glaucoma		Allergies		Hypothyroid		Injury of Large Joint		Cancer Type:
	TIA (mini stroke)		GERD / Reflux		Hyperthyroid		Drug Addiction		
	CVA (stroke)		Irritable Bowel		Heart Valve Issues		Alcohol Addiction		Use Marijuana
	Angina (chest pain)		COPD/Emphysema		Depression		Tobacco Addiction		Smoke Cigarettes
	Heart Attack		Osteoarthritis		Anxiety		Nicotine Dependence		Packs per day:
	Atrial fib / flutter		Rheumatoid Arthritis		Bipolar Disorder		DUI / DWI		Vape

Do you use tobacco?	__Yes, everyday	__Yes, on occasion	__No, former user	__No, never
Check here if you vape_____	(Packs per day_____)			
Do you drink alcohol?	__Yes, everyday	__Yes, socially	__No, former user	__No, never
Beer___ Liquor___	(Drinks per day_____)	(Drinks per week_____)		
Do you use illegal drugs?	__Yes, everyday	__Yes, socially	__No, former user	__No, never
Check here if you use marijuana_____			IV drug use? Yes / No	
Are you currently employed?	__Yes, full time	__Yes, part time	__No, retired	__No, other

Current Employer:_____ Hrs. per week:_____

Medication Allergies:

Name:	Reaction:

Environmental / Food Allergies:

Allergen:	Reaction:

Current Medications: Please be thorough and accurate. If more space is needed, please let the staff know. Include vitamins and supplements.

Name of Medication	Strength (mg)	Frequency of Use	Reason for Use	Prescribing Provider

Hospitalizations/ Surgeries:

Type/ Reason:	Date:	Hospital:

Family Medical History: Please be as thorough as possible. This information allows us to complete the proper screenings necessary for certain medical conditions that may run in your family.

Total # of siblings (including yourself): _____

Sibling Health:

Relation	Age	Living or Deceased	Health Issues

Parent Health:

Mother			
Father			

Grandparent Health:

Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Other Family Health of Importance:

_____

_____

_____

_____

_____

General:	When:	**Eyes:**	When:
__Good Health Lately		__Eye disease or injury	
__Recent unexplained weight loss or gain		__Wear glasses or contacts	
__Fever/Chills/Sweats		__Blurred Vision/Glaucoma/Cataracts	
__Fatigue		__Flashing Lights/Floaters	
__Headaches		__Watery/Itchy/Discharge from eyes	
Ears, Nose, Throat, Mouth	When:	**Cardiovascular:**	When:
__Hearing loss or ringing		__Heart Problems	
__Earache or drainage		__Chest pain	
__Chronic sinus problems/head congestion		__Palpitations	
__Swollen glands in neck		__Shortness of breath	
__Sore throat or voice changes		__Swelling of ankles/hands/feet	
__Environmental Allergies		__Passing out spells	
Respiratory	When:	**Gastrointestinal**	When:
__Chronic or frequent coughs		__Loss of Appetite	
__Spitting/coughing up blood		__Heartburn	
__Asthma or wheezing		__Nausea/Vomiting/Diarrhea/Constipation	
__Shortness of breath		__Change in Bowel Movements	
Musculoskeletal	When:	**Skin**	When:
__Joint pain/stiffness/swelling/warmth		__Rash or itching	
__Weakness of muscles or joints		__Sunburns as a child	
__Muscle pain or cramps		__Change in skin color/moles	
__Back pain		__Change in hair or nails	
__Difficulty walking		__Varicose Veins	
Neurological	When:	**Psychiatric**	When:
__Light-headed or dizziness		__Memory Loss or confusion	
__Convulsions or seizures		__Difficulty with anger	
__Numbness or tingling sensations		__Nervousness	
__Tremors		__Depression	
__Stroke/TIA		__Trouble Sleeping	
__Head Injury		__Hospitalized for emotional problems	
Endocrine	When:	**Hematologic/Lymphatic**	When:
__Gland or hormonal problems		__Slow healing cuts or bruises	
__Thyroid Disease		__Anemia	
__Problems with blood sugar/diabetes		__Past blood transfusions	
__Frequent Thirst for no reason		__Enlarged lymph nodes in groin/armpits	
__Heat or cold intolerance		__Easier bruising than usual for you	
FOR WOMEN:	When:	**FOR MEN:**	When:
Genitourinary		**Genitourinary**	
__Frequent Urination		__Frequent Urination	
__Burning/Painful Urination		__Burning/Painful Urination	
__Frequent urination at night		__Frequent urination at night	
__History of kidney infections/stones		__History of kidney infections/stones	
__Blood in urine		__Blood in urine	
__Vaginal discharge/odor/itching		__Erectile dysfunction	
__Pain during sex		__Testicular pain	
__Lack of sexual desire		__Lack of sexual desire	
__Painful/heavy periods		__Discharge from penis	
__PMS or Menopausal symptoms		__Pain during sex	

Additional health concerns:_____

_____

_____

THIS STUFF IS IMPORTANT:

General Information & Policies

Orchard Health Centers, PLLC (OH) is owned, operated, and managed by Josh Ballard and individuals under his employment or supervision unless otherwise indicated. Care or medical services rendered by OH will be provided or supervised by a Nurse Practitioner (NP) or Physician Assistant (PA), NOT a physician (MD or DO) unless otherwise stated as such at the time of your visit. Though NP and PA providers may hold doctorate level education and professionally may be addressed as "Doctor," NP and PA providers are not physicians.

OH providers are holistic, or all-encompassing, in their approach to care of the patient. This is not to be confused with herbal, natural, alternative, allopathic, osteopathic, or other philosophies of care. Your provider may or may not include these other methods in the care they choose to provide. Our business operates on principles of equality and honesty with the influences of professionalism, faith, hope, and compassion. We expect our patients to treat our staff with these same levels of respect and patience. Dishonest, malicious, or malingering behaviors are not tolerated. Belligerent, disruptive, or abusive conduct, or threats of any kind toward the practice or its employees will be grounds for immediate discharge from our practice and possible legal recourse.

Hospital Affiliation

Currently, Orchard Health Centers, PLLC is not directly associated with any hospital agency.

Diagnostic testing may be performed in a variety of hospital settings at local and/or non-local facilities. To maximize our skills to provide excellent outpatient care, Orchard Health Centers, PLLC has opted to utilize the hospitalist services provided by area medical centers and hospitals in the event patient hospitalization is required. Emergency needs will be directed to the nearest available emergency service provider. It is the policy of some facilities that patients be screened for admission criteria by first being evaluated by their emergency department.

After-Hours Provider Access

After-hours or on-call services are available. Please be respectful of personal and professional boundaries. Providers and staff do not work 24/7. They need personal time with their families and the opportunity to rest and recharge between workdays to better serve our community. Appropriate communication methods (main phone line or fax line) during normal office hours are a must. The on-call line, 828-772-6888, is for urgent matters only that occur outside of normal hours of operation.

DO NOT CONTACT THE PROVIDERS OR STAFF AT HOME OR ON PERSONAL MOBILE DEVICES OR VIA SOCIAL MEDIA!

The on-call service is not to be utilized as a refill request line, appointment line, or to discuss lab results or visit experiences. When calling the on-call line, caller ID that appears as "PRIVATE" may go unanswered and vague messages, such as "call me", will not be returned. On-call messages are screened prior to returning the call.

The on-call line is for URGENT MATTERS AFTER OFFICE HOURS ONLY: For emergencies, please report to your local emergency department or call 9-1-1 Depending on the context of the communication, office encounter fees may be applicable, and the patient/patient's insurance may be billed accordingly. Calls received on the on-call line during normal office hours will be deleted automatically.

Laboratory and Testing Results

Routine testing is typically completed in advance, allowing a planned follow up visit to discuss your results with the provider. For testing not ordered prior to your visit, please permit up to two weeks for a return phone call with your results from our staff. If results are needed more promptly, please arrange a follow-up appointment to discuss accordingly. Tests ordered by outside providers but collected at Orchard Health Centers, PLLC will be forwarded to the ordering provider upon receipt of results without review from this office and such results will need to be obtained/discussed with the ordering provider. You may receive a bill from any laboratory company used for the purpose of test collection.

Medications, Refill Requests, Patient Requests, and Messages

Please bring all of your medication bottles to each appointment, including any products taken over the counter (herbs, vitamins, etc.) as well as any medications prescribed by non-Orchard Health Centers, PLLC providers.

Effective 12/1/2024, refills will only be honored at the time of the office visit or electronic request only. Phoned-in and faxed-in requests will not be accepted. Electronic refill requests (initiated by your pharmacy) will be approved within 3 business days if the request is A) deemed medically appropriate B) received within a reasonable time frame since your last scheduled appointment C) made while your account is in good financial standing D) made after your complete medication list has been verified as accurate and complete. Requests for medication refills need to be submitted to your pharmacy which will in turn notify us electronically of your request for refills.

Again, please allow up to three (3) business days for a response to a refill request. Our office will not contact you after a request has been made or fulfilled unless questions about the request arise. Check for refill verification at the pharmacy rather than contacting our office.

Controlled substance medications due to be refilled require more frequent office visits and this is non-negotiable. Call-in requests for treatment without an office visit are evaluated case-by-case but anticipate if it has been over 90 days since your last appointment, you will be asked to come in to be evaluated. Virtual visits are available and may be encouraged. Phone requests for pain management or mental health will not be authorized and will require an appointment for evaluation. Messages or patient specific requests will be addressed within three business days of receipt. **Form completion requests may require an in-person visit or be subject to additional fees not covered by your insurance.**

Patient Records & Patient Portal Access
Current patients may request a paper copy of his or her records at any time. A fee of $20.00 plus $0.25 per page can be assessed. All record releases require a patient (or legal guardian) and witness signed HIPAA compliant request. As an alternative, Orchard Health Centers, PLLC offers access to a patient portal that can be viewed at any time, free of charge. With a valid email address, patients may enroll in the patient portal, allowing a patient to access his/her medical record information. However, if a patient is discharged or otherwise deactivated from our practice under any circumstance, records (including letter of discharge) will only be released to the patient's new provider.

Records may be released without a signed request as required by law, public health requirements or for appropriate collaborative medical efforts.

Patient Demographic Updates and Scheduling of Appointments
It is the patient's (or patient guardian's) responsibility to ensure current contact information, including phone, mobile phone, email, mailing address, insurance information, etc. prior to the date of his or her next appointment.

PLEASE UPDATE YOUR PERSONAL PROFILE REGULARLY

Required demographic information for every visit:
-Full legal name
-Mailing address
-A working phone number (mobile is preferred)
-Patient date of birth
-All medical insurance information
-Patient's social security number
-Preferred pharmacy

Required information for every patient (prior to scheduling an appointment) includes, but is not limited to, completion of the "new patient packet", which reflects all the above demographic information, as well as comprehensive information about medications in use, past medical/surgical history, and emergency contact information.
We attempt to remind patients via email (requires sign-up), text message, and/or phone about their upcoming appointments. Please be sure your contact information is current. If we call/leave a message about the upcoming appointment, we consider this to be a successful reminder.

Due to limited space and often a quite busy schedule for the provider(s), time allotted for a patient may vary from 10-45 minutes, depending on the need of the patient or procedures to be performed during that visit. When making your appointment, please provide as much information as possible as to the nature of your needs so the receptionist may schedule accordingly. A missed appointment without advanced cancellation can result in taking time away from another patient who would have otherwise benefited from the appointment. With this understanding, we ask that patients maintain awareness of ALL pending appointments with OH. A reschedule fee of $30 may be required to re-activate your account for any missed appointments (or same-day cancellations).

Please know that our provider(s) often have the need to adjust their work schedule due to family concerns, educational issues, or even personal illness. We make efforts to reschedule our patients in advance, but there may be times your visit will be shifted to another provider due to an urgent circumstance. If we can adjust the schedule in advance, you will be offered the option to reschedule with the same or different provider, possibly even having an opening on the same day as the original appointment.

Please be respectful of the provider's time as well as the patients who are waiting to be seen after you. Multiple concerns may or will need to be addressed in separate appointments to avoid scheduling delays. Emergencies and case sensitive issues often create delays during the workday, so please be patient as we help those in crisis first. The order of care priority is as follows: emergencies, scheduled appointments, and then work-in visits. Please note that emergencies occur daily and disruption to our schedule is possible. Please have patience with our staff and provider(s).

To ensure that your time with the provider is maximized, please arrive 15 minutes prior to your appointment time, 30 minutes prior to Wellness Exams

Any patient that is more than seven (7) minutes late for their appointment is subject to cancellation and may have to re-schedule their appointment for another date/time or may wait as a work-in patient based on availability.

Missed Appointment, Same Day Cancellation, Leaving After Triage:

Please note, effective 12/1/2024 our NO SHOW or SAME DAY CANCELLATION policy has changed.

If you are unable to make your appointment time, please contact our office at least 24 hours in advance. Failure to appear for an appointment or make an effort to cancel at least 24 hours in advance will result in a missed appointment status ("NO SHOW").
For this (NO SHOW or SAME DAY CANCELLATION), a $30.00 reschedule fee is applied to your account and must be paid prior to being eligible to reschedule, request refills, or have access to any of the services provided by our facility.
After three (3) NO SHOW or SAME DAY CANCELLATION occurrences, OH reserves the right to discharge the patient from the practice. Three consecutively missed appointments will be considered grounds for immediate dismissal from the practice.
Leaving after having been seen by our nurse or medical assistant but prior to consultation with the provider will result in forfeiture of co-payment or any monies paid for that visit and will be tallied as a NO SHOW or SAME DAY CANCELLATION penalty.

Inclement Weather and Holiday Closure

In the event of inclement weather, please call the office prior to your departure to your appointment. In the case of such weather, we typically will open on a one- or two-hour delay. We will make attempts to adjust the message on our answering machine, as well as update our website and our social media page during days we close due to inclement weather or for a holiday. In the event of complete office closure, such as during staff education days, holidays, or inclement weather, patients with matters needing to be addressed urgently that cannot wait until we reopen, we encourage our patients to visit the nearest emergency room.
Missed appointments during inclement weather are noted within the chart and typically do not apply to our missed appointment policy described above.

Billing and Payment for Services Rendered

Copayments or prior balances are expected to be paid in full at the time of the visit. Special arrangements can be made with our Accounts Manager in advance upon patient request. Questions regarding billing directly from our office need to be directed to our Accounts Manager who can be accessed by calling our main office number. Bills received by the patient that come from other companies that may be used by Orchard Health Centers, PLLC, such as Quest, LabCorp, Atrium Health Wake Forest Baptist, HealthRx, SNAP Diagnostics, etc., need to be directed to the originating company, not Orchard Health Centers, PLLC. It is the patient's responsibility to ensure we have the most current insurance information.

Balances over 90 days must be paid in full before future appointments or medication refills can be authorized.

Self-pay patients, or patients without insurance, please note we require the minimum office fee to be paid prior to seeing the provider. Any additional charges accumulated during your visit or because of the visit will be collected at time of check out. Ask any of our staff members about the different options available to help keep healthcare affordable and manageable.
If you are unable to make minimum payments or cover the cost of an office visit or procedure, notify the staff as this office utilizes "a hand up" approach to help satisfy debts rather than "a handout."

Payment Policy

We require payment of all balances related to your services, including co-pays, deductibles, coinsurance, non-covered service fees, etc. at the time of your visit.
Cash, personal checks, money orders, debit/credit cards, and HSA cards are accepted.

Payment Plans

A **minimum of 30%** must be paid upfront.
Payment of the remainder of balance must be made within 30 days of the rendered service.
A valid credit or debit card must be on file with us to ensure your payment.
In the event of financial hardship, a modified payment plan can be arranged on a case-by-case basis after discussing it with our financial counselor.

Billing Statement and Invoices

We submit claims to your insurance company on your behalf.
Upon receipt of payments from your insurance carrier, any services, or portion of services not covered by your insurance plan will be billed to you. This includes unsatisfied deductible and any out-of-pocket expenses not covered by your carrier.
Full payment is due within 15 days of receipt.
Your account is considered past due 30 days from the date of the first statement.
You will receive a maximum of 3 statements (Initial, Past Due, and Final Notice).
If your account is over 90 days past due and you have not made a payment arrangement, your account may be turned over to a collection agency, including the fees charged by the agency for collection purposes.
Failure to pay the remaining balances can result in the termination of your care from our practice.

HIPAA CONTACT INFORMATION: (Please list below) The people you list below will be able to receive information about you or your results, medications, etc. in the event we are unable to reach you. If your spouse, or any other person is not listed below, we will be unable to talk to them about anything related to you and/or Orchard Health.

NAME	RELATIONSHIP	PHONE NUMBER

*HIPAA Release: The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect privacy. Implementation of HIPAA requirements officially began on April 14, 2003.
Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as a patient. Orchard Health Centers, PLLC. balances these needs with the goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

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Please initial after reading each statement

____ I have completed this form to the best of my knowledge and attest to the validity of the information contained herein. I have read and understand all policies above and further understand it is my responsibility to maintain awareness of the most up-to-date policies and requirements to maintain compliance with being a patient of Orchard Health Centers, PLLC. I further agree to keep my demographic and health information current with Orchard Health. I will keep my account in good standing and maintain financial responsibility with appropriate accountability.

____ Orchard Health Centers PLLC. utilizes their affiliate practice, Ashe Family Healthcare, and their medical insurance billing and coding specialist to process insurance claims and debit/credit card payments. As such, you will see Ashe Family Healthcare (AFH) listed on many billing and statement notices. If you have any questions about your billing/insurance statements, please contact Orchard Health at 336-990-9540.

Patient Name (Printed):_____

Patient Signature: _____ **Date:**_____

If patient is under the age of 18:

Parent/Legal Guardian Name (Printed): _____

Parent/Legal Guardian Signature: _____ **Date:** _____