Hudson Primary Care
New Patient Triage Tool

☐ Dr. Richard McBurney

In order to continue to provide excellent care to our current patient and yet make the office available for patients who do not currently have a medical provider, we need to gather some information to determine how quickly we can fit you into our schedule based on illness, severity and the complexity of your needs. Please understand **that this office does not accept patients who are being seen for chronic pain management.** You must agree in writing that you are **not taking and will not request Hydrocodone, Oxycodone, Percocet, Dilaudid, Morphine or any similar long-term narcotic pain medications**. All pain management patients will be referred to pain management and you must agree in writing that you will never ask Dr. McBurney for those medications. All patients will be check on the state website to verify whether or not you are taking chronic pain medications from other providers. Patient requiring medications such as **Valium, Ativan, or Xanax need to know in advance that those medications also will not be provided through this office but will be provided only upon referral to RHA or psychiatry.**

I agree that I am not taking any of the above medications and will not request these medications at any time while being cared for by Dr. McBurney.

Name: _____ Date of Birth _____

Address: _____

City: _____ State _____ Zip _____

Cell Phone: _____ Home Phone: _____

Work Phone: _____ Place of Employment: _____

Signature: _____ Date: _____

MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Hudson Primary Care. When you schedule an appointment with Hudson Primary Care we set aside enough time to provide you with the highest quality care. Should you need to cancel or rescheduled an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Effective August 1, 2018 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours notice** will be considered a No Show and charged a **$25.00 fee**. If this visit is for a **wellness exam**, Medicare Physical, or child wellness visit **$75.00 fee** will be charged.
- Any established patient who fails to show or cancels/reschedules an appointment with no 24 hour notice a **second** time will be charged a **$50.00 fee**.
- If a **third** No Show or cancellation/reschedule with no 24 hour notice should occur the patient may be **dismissed** from Hudson Primary Care.
- Any **new patient** who fails to show for their initial visit **will not** be rescheduled.
- The fee is charged to the patient, not the insurance company, and is **due at the time of the patient's next office Visit or before.**
- As a courtesy, when time allows, we make reminder calls for appointments at least two days prior to your appointment. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show fee. You may contact Hudson Primary Care 24 hours a day, 7 days a week at the numbers below. Should it be after regular business hours Monday through Friday, or a weekend, you may leave a message..

Hudson Primary Care (828)728-0900
Hudson Primary Care (828)728-0909

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

Signature (Parent/Legal Guardian) _____ Relationship to Patient _____

Printed Name _____ Date _____

Hudson Primary Care PA

PLEASE PROVIDE INSURANCE CARD(S) & PHOTO ID OR DRIVERS LICENSE

Today's Date: _____ SS #: _____ **DOB:** _____

PATIENT INFORMATION:

Patient's Name: _____
(First Name) (M.I.) (Last Name)

I preferred to be addressed as / My nickname is: _____ Sex: ☐ M ☐ F

Address: _____
(Street Address) (City/State) (Zip Code)

Billing" Address: _____
(Street Address) (City/State) (Zip Code)

Home Phone: (____) _____

Cell Phone: (____) _____

Email: _____

PRIMARY CARE/REFERRING PHYSICIAN INFORMATION:

Did a Physician Refer You? ☐ NO ☐ YES Name: _____

Prior Primary Care Physician: _____

How did you find us? Were you referred by:

Physician_____	Insurance Book_____	Internet _____
Family or friend *(name):* _____	Prior Patient_____	Newspaper Ad___
Other *(please specify)* _____	Saw our Billboard___	Mailing _____

FOR MINORS ONLY: PARENT OR LEGAL GUARDIAN INFORMATION –

Parent or Legal Guardian Name: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell: (____)_____

DEMOGRAPHICS:

1) **Race:** American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White
☐ Native Hawaiian ☐ Other Pacific Islander ☐ More than One Race ☐ Refuse to Report

2) **Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic ☐ Unknown

3) **Preferred Language:** ☐ English ☐ Spanish ☐ Other

4) **Preferred Notification Method:** ☐ Postal Mail ☐ Phone ☐ Email

5) **Marital Status:** ☐ M ☐ S ☐ D ☐ W ☐ Full time student

EMERGENCY CONTACT INFORMATION

In case of emergency, whom should we notify? _____

Relationship to Patient: _____Phone: (____)_____

PATIENT EMPLOYMENT INFORMATION

Patient's Employer Name & Address: _____

Employer's Phone (_____)_____ ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed

INSURANCE COVERAGE: (we will need to make a copy of your cards – please provide your cards)

Primary Company Name:_____

Secondary Company Name:_____

Note: Except for exceptional cases we will only file with your **primary** carrier. This policy **excludes** patients with Medicare.

DISCLOSURES OF MEDICAL INFORMATION TO FAMILY MEMBERS AND FRIENDS

I hereby give my permission to disclose personal medical information about my treatment to the following individuals:

☐ Same as Emergency Contact.

☐ I do **NOT** give permission to disclose personal medical information about my treatment to family members or friends.

I authorize release of medical information to my primary care, referring doctors and consultants.

I authorize you to send me practice related emails.

These are the additional persons I give my permission to disclose information about my medical treatment:

Name: _____ Relationship: _____ Phone #: (___) _____

Name: _____ Relationship: _____ Phone #: (___) _____

MAY WE LEAVE PERSONAL MEDICAL INFORMATION ON YOUR ANSWERING MACHINE?

☐ **YES** ☐ **NO**

PHARMACY INFORMATION (we transmit all prescriptions through the computer!)

Local Pharmacy Name: _____ Phone #: (___) _____

Address: _____

Mail Order Pharmacy Name: _____ Phone #: (___) _____

Address: _____

ALL PATIENTS PLEASE READ AND INITIAL

Receipt of Notice of Privacy Practices Written Acknowledgment Form:

I hereby acknowledge that I have been provided with an opportunity to review the privacy notice of health information practices of HUDSON PRIMARY CARE PA. _____ (initials)

CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFITS, AND FINANCIAL POLICIES

I. Consent for treatment: I authorize HUDSON PRIMARY CARE PA, its agents, and Richard McBurney, MD and/or Amanda Du Sablon DO MD to render treatment to me/my dependents for Family Practice and medical/surgical care.

II. Assignment of Benefits/Release of medical information: I request that payment for authorized Medicare or other applicable private insurance benefits be paid directly to HUDSON PRIMARY CARE PA for services provided under their care. I also authorize HUDSON PRIMARY CARE PA to release necessary medical information to my insurance company, its agents, or any third party in order to determine payable benefits for the services rendered.

III. Digital Photography: I authorize the physicians/staff of HUDSON PRIMARY CARE PA to take digital photographs that relate to my care. HUDSON PRIMARY CARE PA will only disclose information relevant to my care to permitted persons and any and all physicians who care for me. The photographs may be used for teaching, academic and research purposes so long as my identity is concealed.

IV. Financial Responsiblity: I understand that I am ultimately responsible for any unpaid balance or non-covered service and am responsible for all costs of pursuing such balances if I fail to pay.

V. Referrals/Authorization: I understand that if my insurance company requires a referral, I am responsible for obtaining a referral prior to my visit. If I do not have a referral at the time of service, no services will be rendered until I obtain a referral or sign a waiver of financial responsibility. Payment in full is required at the time of service.

VI. Missed Appointments: Our office requires 24 hour notice for cancellations. Failure to do so may result in a $50.00 fee.

I have reviewed the statements above and understand my responsibilities and if I don't understand my responsibilities, I agree that I can ask questions!

Patient/Legal Guardian Signature: _____ Date: _____

Print Name: _____

FOR MEDICARE PATIENTS ONLY

Medicare Authorization: I request that payment for Medicare Benefits be made on my behalf to HUDSON PRIMARY CARE PA for any services provided to me by its Providers. I authorize HUDSON PRIMARY CARE PA to release to the CMS and its agents any information needed to determine these benefits payable for related services. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare benefits apply.

MEDICARE IS NOT ALWAYS THE PRIMARY INSURANCE. FEDERAL REGULATIONS REQUIRE THAT WE OBTAIN INFORMATION TO DETERMINE IF ANOTHER INSURER MAY BE PRIMARY TO MEDICARE:

1. Do you or your spouse now work in a company which has 20 or more employees and have insurance at the job? ___Yes ___No

2. Are you covered by an HMO/PPO which makes Medicare secondary? ___Yes ___No

3. Is this illness/injury covered by the VA? ____Yes ____No

4. Is this illness /injury covered by Federal Black Lung or End Stage Renal Disease Program? ____Yes ____No

5. Is this illness/injury due to an automobile accident? ____Yes ____No

6. Is this illness/injury due to work related causes? ____Yes ____No

Patient Signature:____ Date:__________________________

A copy of this signature will be used for release of information to your insurance companies and for assignment of benefits to Dr. Martin and HUDSON PRIMARY CARE PA.

CO-PAYMENT AND DEDUCTIBLE ARE DUE WHEN SERVICES ARE RENDERED: NO EXCEPTIONS PLEASE, THANK YOU!

♦♦

Hudson Primary Care
109 Fairway Shopping Center
Hudson, NC 28638

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ _____
Print patients full name Birthdate (Mo/Day/Yr)

_____ _____
Street Address Phone (Home)

_____
City, State, Zip

At the request of the individual I _____, do hereby authorize the release of:
(Patients name)

___Discharge Summary ___Pathology Reports ___Emergency Reports
___History & Physical ___Lab Reports ___Other _____
___Progress Notes ___Radiology Reports ___ _____
___Operative Notes ___ECG/EKG/Cardiac Cath ___All

INFORMATION RELEASED FROM:

_____
Name of Company/ Agency/Facility/

_____
Street Address

_____
City, State, Zip

_____
Phone Fax

INFORMATION RELEASED TO:

HUDSON PRIMARY CARE

109 Fairway Shopping Center

Hudson, NC 28638

828-728-0900 828-728-0868
Phone Fax

I hereby authorize disclosure of health information for the above named patient. This authorization is valid indefinitely from the date of signature. I understand that I may cancel this request with written notification but that will not affect any information release prior to notification of cancellation.

_____ _____ _____
Signature of individual/guardian/representative Date Signature of Witness

HUDSON PRIMARY CARE

PATIENT HISTORY QUESTIONNAIRE

Richard McBurney, MD

Date: _____

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

Address: _____

Best Contact Phone number _____

Current Routine Medications, Vitamins, Herbs, Over-the-counter, etc:

Drug Name	Dose	What time of day taken	Who prescribed

No Medications ☐

Pharmacy: _____ **Mail in Pharmacy:** _____

Allergies to Medications/Foods: Type of reactions:

No Known Drug Allergies ☐

Past Medical History (have you ever had):

Arthritis	☐ Yes	☐ No	When Diagnosed_____
Asthma	☐ Yes	☐ No	When Diagnosed_____
Cancer/Type: _____	☐ Yes	☐ No	When Diagnosed_____
Cholesterol Problems	☐ Yes	☐ No	When Diagnosed_____
Diabetes	☐ Yes	☐ No	When Diagnosed_____
Diverticulitis/osis	☐ Yes	☐ No	When Diagnosed_____
Ear Problems	☐ Yes	☐ No	When Diagnosed_____
Heart Disease	☐ Yes	☐ No	When Diagnosed_____
High Blood Pressure	☐ Yes	☐ No	When Diagnosed_____
Kidney Disease	☐ Yes	☐ No	When Diagnosed_____
Liver Disease	☐ Yes	☐ No	When Diagnosed_____
Lung Problems	☐ Yes	☐ No	When Diagnosed_____
Seizures	☐ Yes	☐ No	When Diagnosed_____
Strokes	☐ Yes	☐ No	When Diagnosed_____
Thyroid Problems	☐ Yes	☐ No	When Diagnosed_____
Tuberculosis	☐ Yes	☐ No	When Diagnosed_____
Other serious medical conditions	☐ Yes	☐ No	When Diagnosed_____

ALL INFORMATION CONTAINED IN THIS QUESTIONNAIRE IS STRICTLY CONFIDENTIAL

Date: _____

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

If additional comments or explanation needed on past medical history:

Past Surgical History (any operations, where and year):

Hospitalizations (Were you in the hospital within past 5 years? What was the reason for the hospitalization and what year did it occur? Which Hospital/Facility?)

Preventative Medicine:

Tetanus shot ☐ Yes ☐ No Month/Year _____

Flu shot ☐ Yes ☐ No Month/Year _____

Eye exam ☐ Yes ☐ No Month/Year _____

Dental Exam ☐ Yes ☐ No Month/Year _____

Pneumonia vaccine ☐ Yes ☐ No Month/Year _____

Colonoscopy ☐ Yes ☐ No Month/Year _____

Prostate Exam ☐ Yes ☐ No ☐ n/a
Month/Year _____ Where _____

Mammogram ☐ Yes ☐ No ☐ n/a
Month/Year _____ Where _____

Pap Smear ☐ Yes ☐ No ☐ n/a
Month/Year _____ Where _____

Bone Density ☐ Yes ☐ No ☐ n/a
Month/Year _____ Where _____

Social History:

Language: English _____ Other _____

Impairments: Hearing _____ Visual ____ Illiterate ___ Speech ____

(Please Circle): Married Single Divorced Separated Widowed Homosexual Bisexual

Occupation _____ Place of Employment: _____

Education _____ Number of Children _____male _____female

Tobacco Use ☐ Yes ☐ No Type _____ Amount Frequency _____

Former _____ Stop Date: _____

Alcohol Use ☐ Yes ☐ No Type _____ Amount/Frequency _____

Caffeine Use ☐ Yes ☐ No Type _____ Amount/Frequency _____

Illegal Drug Use ☐ Yes ☐ No Type _____ Amount/Frequency _____

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Date: _____

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

Family History (significant medical problems – blood relative):

☐ Unknown / Adopted

List all blood relatives who have had the following medical problems- use abbreviations:
(F) father, (M)mother, (B)brother, (S)sister, (MM)mother's mother, (MF)mother's father, (FM)father's mother, (FF)father's father, (A) aunt, (U)uncle, (C)cousin

Illness	Which Family Members	Was this cause of death
Alzheimers		
Asthma		
Cancer(Describe type)		
Diabetes		
Drug or alcohol addiction		
Glaucoma		
Gout, arthritis, lupus		
Headaches, Migraines		
Heart Disease		
High Cholesterol		
Hypertension (High Blood Pressure)		
Learning disability		
Mental Disease (Anxiety, Depression, etc.)		
Stroke/TIA		
Other (specify)		

Other Medical Providers:

Name of Doctor/ Practice	**Specialty-Type of Doctor**	**Last visit**
	Dentist	
	Eye Doctor	
	Orthopedist	
	Pain Management	
	ENT	
	Endocrinologist	
	Surgeon	
	Psychiatrist/Therapist	
	Other:	

ALL INFORMATION CONTAINED IN THIS QUESTIONNAIRE IS STRICTLY CONFIDENTIAL

Date:_____

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

Review of Systems (Other problems – Check if significant problems within past 3 months)

General

Weight Change	☐ Yes	☐ No
Appetite Change	☐ Yes	☐ No
Energy Level Change	☐ Yes	☐ No

HEENT

Headaches	☐ Yes	☐ No
Eyes	☐ Yes	☐ No
Ears	☐ Yes	☐ No
Nose	☐ Yes	☐ No
Throat	☐ Yes	☐ No

Neck

Swelling	☐ Yes	☐ No
Tenderness	☐ Yes	☐ No
Goiter	☐ Yes	☐ No

Chest

Pain	☐ Yes	☐ No
Pressure	☐ Yes	☐ No
Racing Heart (palpitations)	☐ Yes	☐ No

Breasts

Tenderness	☐ Yes	☐ No
Lumps	☐ Yes	☐ No

Lungs

Chronic Cough	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Blood in Sputum	☐ Yes	☐ No

Digestive System

Abdominal Pain	☐ Yes	☐ No
Nausea	☐ Yes	☐ No
Change in Bowel Habits	☐ Yes	☐ No
Black Tarry Stool	☐ Yes	☐ No
Bloody Stools	☐ Yes	☐ No

Genitourinary

Urinary Pain	☐ Yes	☐ No
Change in Urinary System	☐ Yes	☐ No

Gynecological

Last Menstrual Period (Date)		_____
Hysterectomy	☐ Yes	☐ No
Number of Pregnancies		_____
Number of Children		_____
Vaginal Discharge	☐ Yes	☐ No

Neurological

Weakness in Arms/Legs	☐ Yes	☐ No
Dizziness/Fainting	☐ Yes	☐ No
Stroke/TIA	☐ Yes	☐ No

Extremities

Swelling of Hands/Feet	☐ Yes	☐ No
Varicose Veins	☐ Yes	☐ No
Leg Cramps	☐ Yes	☐ No

Skin

Rashes	☐ Yes	☐ No
History of Skin Cancer	☐ Yes	☐ No

Musculoskeletal

Joint Pain or Swelling	☐ Yes	☐ No
Rheumatoid Arthritis	☐ Yes	☐ No
Low Back Pain	☐ Yes	☐ No

Psychological

Depression	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Sexual Difficulties	☐ Yes	☐ No
Abuse by Spouse or Other	☐ Yes	☐ No
Alcohol or Drug Addiction	☐ Yes	☐ No
Other	☐ Yes	☐ No

Any other problems:

Do you have a Living Will (Advance Directive)? ☐ Yes ☐ No

Would you like information on Living Will (Advance Directive)? ☐ Yes ☐ No

_____ _____

Patient Signature **Date**

Form completed by_____ **Relationship to patient**_____

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