SHAE Medical
Phone: 919-646-4858 Fax: 919-679-7112 shaemedical.com
5306 NC Highway 55, Suite 105 Durham, NC 27713-7812

Scan QR Code to Submit Securely Online

PATIENT DEMOGRAPHICS : ☐ Attach photocopy of patient's ID OR ☐ Email to registration@shaemedical.com

First Name: _____ Middle _____ Last _____ Preferred Name: _____

DOB ___/___/___ Social Security # _____ Gender: ☐ Male ☐ Female

Phone number (check preferred): ☐ HOME _____ ☐ Cell: _____ ☐ I Consent to SMS texts

Patient Email Address: _____ Race: _____ Ethnicity: _____

REQUESTED LOCATION OF MEDICAL CARE REQUEST: ☐ SHAE Medical Office ☐ Facility ☐ Home

Facility/Community Name: _____

Home/Facility Address (including room number): _____

PREFERRED PHARMACY: Name: _____ Phone: _____

INSURANCE INFORMATION: ☐ attach photocopy of insurance card(s), OR ☐ Email to registration@shaemedical.com

Medicare #: _____ Medicaid #: _____

Other/Supplemental Policy: _____

FORM OF PAYMENT: Card will be kept on file but not be charged until time of service for co-pays (if required) and after insurance has been billed for any deductibles required for collection by patient's insurance.

Name on Card: _____ Card Number: _____

Expiration (Month/Year): _____ CVV: _____

RESPONSIBLE PARTY: Is patient capable of making own healthcare decision: ☐ Yes ☐ No

Check Applicable: ☐ Healthcare POA ☐ Financial POA ☐ Legal Guardian ☐ Patient is responsible

Primary Emergency Contact/Healthcare POA/Legal Guardian: ☐ legal docs attached ☐ email to registration@shaemedical.com

Name: _____ Phone (_____) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Relationship to Patient: _____ Email Address: _____

Additional Name and contact information of any other individuals allowed to obtain details in patient care information

Name: _____ Phone (_____) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Updated 1.9.2024

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PATIENT FULL NAME: _____ **PATIENT DATE OF BIRTH:** _____/_____/_____

Consent for Service & Medications, Authorization of Payment & Record Release, Advance Beneficiary Notice (ABN)

1. I request for medical services of SHAE Medical, PLLC and request that payment authorized insurance (including Medicare) benefits be made on my behalf to SHAE Medical, PLLC for medical services including but not limited to:
    a. Chronic care management
    b. Integration of behavioral health integration care management services
    c. Tele-health visits and all communication-based technology services
2. I authorize the release of my medical records to SHAE Medical, PLLC upon its request for dates of treatment going back 2 years from the date below, including all discharge summaries, progress notes, consult notes, laboratory testing, and imaging studies.
3. I consent for the medical records to be shared between healthcare providers that are enrolled in the Carequality and Commonwell Interoperability network. Carequality/Commonwell supports secure access to health information across diverse networks, including those operated by electronic health record vendors, record locator service providers, health information exchanges, and others.
4. I authorize SHAE Medical, PLLC to release to my insurance company and/or to the Centers for Medicare and Medicaid Services and its agents and information needed to determine these benefits or the benefits payable to/for related services, including but not exclusive of a clinical diagnosis, treatment plans and summaries and/or copies of the entire record. I also agree that SHAE Medical, PLLC can provide the requested information to my insurance carrier.
5. I acknowledge that I am financially responsible for all charges for services provided to me, including but not limited to any portions of my medical care that my insurance company assigns to me for in-person and non-face-to-face services provided. Once insurance is filed, I authorize the use of my credit or debit card for payment of these balances owed. I understand that my credit card will be securely saved on file for future transactions on my account until expiration of provided card. My responsible party/financial agent can be informed that I am receiving services for billing purposes unless I request otherwise.
6. I understand my records will be kept on file at the facility where services are provided and securely in an Electronic Medical Record.
7. I authorize SHAE Medical, PLLC to seek emergency medical care on my behalf if deemed necessary.
8. I understand there are risks, side effects, benefits, and possible drug-drug interactions of medication(s) prescribed. I and/or my legal guardian, understand there are risks, where applicable, during pregnancy, in the elderly, and other pertinent risk factors such as FDA black box warnings. I and/or my legal guardian are indicating awareness and have given informed consent for medication(s) and or therapies to be prescribed for their intended use as part of the treatment process.
9. I acknowledge review of the SHAE Medical, PLLC Notice of Privacy Practices and Client Rights and Grievance Policies. A copy is available on our website at shaemedical.com/npp . If requested, a copy will be provided to me.
10. I acknowledge review of the SHAE Medical HIPAA Policy which is located on the website at shaemedical.com/hipaa. If requested, a copy will be provided to me.
11. I acknowledge that I have the right to refuse treatment as described in the statute without threat or termination of services except as outlined in G.S. 122-C-57(d); 10A NCAC 27D . 0303 (c). This consent for treatment may be withdrawn at any time.

Printed Name of Patient/HCPOA: _____ Signature of Patient/ HCPOA _____

Specify relationship (if not patient) _____ Date _____

Advanced Beneficiary Notice—NOTE: please check ACCEPT or DECLINE; for more information, check out shaemedical.com/abn

☐ *I **ACCEPT** that Medicare does not pay for the trip charge service for a clinician to provide in-home medical care or for the trip charge associated with an urgent visit for services at the home/facility on a non-scheduled day. If I request, I authorize payment of **$125 charge** for in-person medical services.*
☐ *I **DECLINE** in-home care and/or urgent visits for in-person medical services on non-scheduled days.*

Printed Name of Patient/HCPOA: _____ Signature of Patient/ HCPOA _____

Specify relationship (if not patient) _____ Date _____

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PATIENT FULL NAME: _____

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Patient History Questionnaire

PREVIOUS PRIMARY CARE PROVIDER or CURRENT SPECIALISTS (Cardiologist, etc): _____

_____

MEDICATION LIST : ☐ copy attached to this packet, OR ☐ list sent via email to registration@shaemedical.com

Name of Medication	Dosage	Quantity	How often taken	Date started if known

ALLERGIES: _____

HOSPITALIZATION HISTORY (last 2 years): _____

SURGICAL HISTORY: _____

FAMILY HISTORY:

MOTHER: ☐ Living ☐ Deceased, if so, age: _____ Medical History: _____

FATHER: ☐ Living ☐ Deceased, if so, age: _____ Medical History: _____

BROTHER(S) OR SISTERS: ☐ Living #_____ ☐ Deceased, if so, age: _____ Medical History: _____

CHILDREN: ☐ Living #_____ ☐ Deceased, if so, age: _____ Medical History: _____

SOCIAL HISTORY:

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed **Occupation:** _____

Level of Education ☐ Grade: _____ ☐ High School/ GED ☐ College ☐ Post-Graduate Degree: _____

Tobacco Use ☐ Current, #/day _____ # Years used: _____ ☐ Former Smoker, Quit Date _____ ☐ Never

Alcohol Use ☐ Personal History of Alcoholism ☐ Current: # Drinks/day _____ or # Drinks/week _____ ☐ Never

Drug Use: ☐ Personal History of Drug/Illicit Substance Abuse, Type: _____ Quit Date: _____

☐ Current user, Substance of use: _____, amount/frequency used: _____ ☐ Never

PREVENTATIVE HISTORY: *Has patient received any of the following, please include date(s) if known:* ☐ Influenza _____

☐ Prevnar13 _____ ☐ Pneumococcal 23 _____ ☐ COVID-19 _____ ☐ Tetanus/Tdap _____

☐ Colonoscopy _____ ☐ Mammogram _____ ☐ Bone Density/DEXA _____ ☐ Eye Exam _____

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