SURRY RURAL HEALTH CENTER

113 Scenic Outlet Lane, Mount Airy, NC 27030
Phone: 336-352-4900 Fax: 336-352-4901

Patient's Rights & Responsibilities

You have the right to:

- A personal clinician who will see you on an on-going, regular basis.
- Competent, considerate, and respectful health care regardless of race, age, sex, religion or sexual orientation.
- A second medical opinion from the clinician of your choice at your expense.
- A complete, understandable explanation of your condition, treatment, and chances of your recovery.
- The personal review of you own medical records by appointment and in accordance with applicable State and Federal guidelines.
- Confidential management of communication and records pertaining to your medical care.
- Information about the medical consequences of exercising your right to refuse treatment.
- The information necessary to make an informed decision about any treatment or procedure, except as limited in an emergency.
- Be free from mental, physical, and sexual abuse.
- Humane treatment in the least restrictive manner appropriate for treatment needs.
- An individualized treatment plan.

You are responsible for:

- Giving your clinician correct and complete health history information (ex. Allergies, past and present illnesses, medications, and hospitalizations).
- Providing staff with correct and complete name, address, telephone, and emergency contact information each time you see your clinician, so we can contact you.
- Providing staff with current insurance information including any secondary insurance.
- Signing a "Release of Information" form when asked so your clinician can receive and review your medical records involved in your care.
- Telling your clinicians about all medications you are currently using, including over-the-counter medications, herbal, or other therapies.
- Telling your clinician about any changes in your condition, medications, or reactions to medications.
- Asking your clinician questions when you do not understand your illness, medication, or treatment plan.
- Following your clinician's advice. If you refuse to follow instructions given by your health care clinician, you are responsible for any medical consequences.
- Keeping your appointments. If you need to reschedule or cancel your appointment, please contact the office at least 24 hours in advance.
- Paying copayments at the time of your visit and paying bills upon receipt.
- Following the rules in the office about conduct (ex. No smoking in office).
- Respecting the rights and property of our staff and others in the office.

New Patient Form

Demographics

Full Name (first, middle, last) _____

Date of Birth _____ Gender: ▢Male ▢Female Social Security #_____

Preferred Language _____ Race (optional) _____

Address _____ City_____ State_____ Zip_____

Home #_____ Cell #_____ Email _____

Marital Status: ▢Single ▢Married ▢Divorced ▢Separated ▢Widowed

Employer Information

Employment Status ▢Employed ▢Unemployed ▢Retired ▢Semi-retired ▢Student

Employer_____ Occupation_____

Employer Address_____City_____State____Zip_____

Emergency Contact Information

Full Name _____ Relationship to patient _____

Home #_____ Cell #_____

I acknowledge that providing my phone number(s) gives Challie Minton MD PC permission to call that number.

I designate and authorize Medicare payments directly to Challie Minton MD PC for any benefits payable for services rendered.

I hereby authorize Challie Minton MD PC to release any medical information to the insurance company(s) that I designate, and to the agents, to determine benefits or benefit related services.

I authorize payment directly to Challie Minton MD PC for any benefits payable for services rendered. I understand that regardless of whether any insurance is applicable, I am responsible for this account in full, including any copayments or deductibles due at the time of my visit.

I acknowledge that I have received a copy of Challie Minton MD PC Notice of Privacy Practices.

I authorize Challie Minton MD PC to treat me as a patient. I authorize such care, treatments, and/or diagnostic studies to be performed as are deemed necessary by my healthcare provider.

Signature _____ Date _____

If signed by representative, please state relationship to Patient _____

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24 Hour Cancelation & "No Show" Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Challie Minton MD PC reserves the right to charge a fee of $40.00 for all missed appointments ("no shows") that are not canceled with a 24-hour notice. "No show" fees will be billed to the patient. This fee is not covered by your health insurance and must be paid prior to your next appointment. Multiple "no shows" in any 12-month period may result in termination from our practice.

Thank you for understanding and cooperating as we strive to serve the needs of all our patients.

By signing below, you acknowledge that you have read this notice and understand this policy.

Signature _____ Date _____

If signed by patient's representative, please state Relationship _____

HIPAA Compliance Consent Form

Our notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change. If the terms change, you will be notified at your next visit to update your signature.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that my protected health information may be disclosed or used for treatment, payment, or healthcare operations. The practice reserves the right to change the privacy policy as allowed by law. The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions. The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease. The practice may condition receipt of treatment upon execution of this consent.

May we call, email, or send text to you to confirm appointments? ▢Yes ▢No
May we leave a message on your answering machine or voicemail? ▢Yes ▢No
May we discuss your medical condition with anyone other than yourself? ▢Yes ▢No
If yes, please list the people we are given permission to talk to ▢Yes ▢No

Name _____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____

Print name _____

Signature _____ Date _____

Witness _____ Date _____

Name: _____

Patient Preventative Questionnaire

Please fill in this information below as accurately as you can. If you know you have had the test and you do not know the exact date, put approximate month and year. If it does not apply to you, check N/A.

Test	Yes	No	N/A	Date
Colonoscopy	▢	▢	▢	_____
Bone Density	▢	▢	▢	_____
Dilated Eye Exam	▢	▢	▢	_____
Mammogram	▢	▢	▢	_____
Pap Smear	▢	▢	▢	_____
Tetanus Vaccine	▢	▢	▢	_____
Flu Vaccine	▢	▢	▢	_____
Pneumonia Vaccine	▢	▢	▢	_____
Shingles Vaccines	▢	▢	▢	_____
Annual Physical/Wellness	▢	▢	▢	_____

Drug Abuse Screening Test (DAST-10)

The following questions concern information about your possible involvement with drugs (not including alcoholic beverages) during the past 12 months. “Drug abuse refers to the use of prescribed or over-the-counter drugs in excess of the directions and any nonmedical use of drugs. The various classes may include cannabis, marijuana, hashish, solvents (ex, paint thinner), tranquilizers (ex. valium), barbiturates, cocaine, stimulants (ex. speed), hallucinogens (ex. LSD) or narcotics (ex. heroin).

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly correct or if you feel it does not apply to you, write N/A beside the question.

In the past 12 months…	Yes	No
Have you used drugs other than those required for medical reasons?	▢	▢
Do you abuse more than one drug at a time?	▢	▢
Is it difficult to stop using drugs when you want to?	▢	▢
Have you ever had blackouts or flashbacks as a result of drug use?	▢	▢
Do you ever feel bad or guilty about your drug use?	▢	▢
Does your spouse (or parents) ever complain about your involvement with drugs?	▢	▢
Have you neglected your family because of your drug use?	▢	▢
Have you engaged in illegal activities in order to obtain drugs?	▢	▢
Have you ever experienced withdrawal symptoms when you stopped taking drugs?	▢	▢
Have you had medical problems as a result of drug use (ex. memory loss, hepatitis)?	▢	▢

Scoring: scoring 1 point for each question answered “yes”. **Score:**

Interpretation of score

Score	Degree of problems related to drug abuse	Suggested action
0	No problems reported	None at this time
1-2	Low level	Monitor, reassess later
3-5	Moderate Level	Further investigation
6-8	Substantial Level	Intensive Assessment
9-10	Severe Level	Intensive Assessment

Patient Medical History Form

Name _____ Date of Birth _____

Preferred Pharmacy _____

Please complete form the best you can. If you need additional space for any section, please let a staff member know.

Current Medications

Name	Dosage	How Often

Please list any allergies below ▢ No known Allergies

Allergy to	Reaction

Family History- indicate any diseases that your family members have been diagnosed with
*Example: Diabetes, High Blood Pressure, Cancer, Lung diseases, Strokes

Family Member	Disease(s) or Problem(s)

Menstrual History

# of Pregnancies _____ Number of Miscarriages _____ Last Menstrual Cycle _____

Name: _____

Headaches	▢Yes	▢No	Approximate Date _____
Trouble with vision	▢Yes	▢No	Approximate Date _____
Trouble with hearing	▢Yes	▢No	Approximate Date _____
Allergies: Hay fever? Asthma?	▢Yes	▢No	Approximate Date _____
Thyroid	▢Yes	▢No	Approximate Date _____
Diabetes	▢Yes	▢No	Approximate Date _____
Skin problems	▢Yes	▢No	Approximate Date _____
Shingles	▢Yes	▢No	Approximate Date _____
Anemia/ abnormal bleeding	▢Yes	▢No	Approximate Date _____
Heart problems	▢Yes	▢No	Approximate Date _____
Circulation problems	▢Yes	▢No	Approximate Date _____
High/low blood pressure	▢Yes	▢No	Approximate Date _____
Chest pain	▢Yes	▢No	Approximate Date _____
Lung problems	▢Yes	▢No	Approximate Date _____
Shortness of breath or coughing	▢Yes	▢No	Approximate Date _____
Wheezing	▢Yes	▢No	Approximate Date _____
Liver Disease or Jaundice	▢Yes	▢No	Approximate Date _____
Gallbladder disease	▢Yes	▢No	Approximate Date _____
Stomach problems	▢Yes	▢No	Approximate Date _____
Change in Bowels	▢Yes	▢No	Approximate Date _____
Abdominal pain	▢Yes	▢No	Approximate Date _____
Kidney disease or stones	▢Yes	▢No	Approximate Date _____
Urinary problems	▢Yes	▢No	Approximate Date _____
Female/male issues	▢Yes	▢No	Approximate Date _____
Joint pain or stiffness	▢Yes	▢No	Approximate Date _____
Depression	▢Yes	▢No	Approximate Date _____
Anxiety/nerves or trouble sleeping	▢Yes	▢No	Approximate Date _____
Psychiatric	▢Yes	▢No	Approximate Date _____
Fainting spells	▢Yes	▢No	Approximate Date _____
Stroke	▢Yes	▢No	Approximate Date _____
Weight loss/gain	▢Yes	▢No	Approximate Date _____

Other_____

_____

Social History

Do you smoke? ▢Yes ▢No If no, are you a former smoker? ▢Yes ▢No

If yes to either question, how long? _____ How much per day? _____

Do you drink alcoholic beverages? ▢Yes ▢No If yes, how often? _____

Surgical History

Type of Surgery	Name of facility	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____