PATIENT REGISTRATION

Last Name: ________________________________ First Name: ________________________________ M.I. ______

Date of Birth: ______/______/________ Email address: ____

Primary phone number: _______-_______-_________ Alternative phone number: _______-_______-_________

Have you been seen as a patient at this facility? Yes No

If yes, please complete questions below.

If no, complete HIPAA then go to New Patient Information.

Since your last visit, have you had any changes to the following	Yes	No	Comments (Please provide new information)
Home address			
Phone number			
Insurance Information			

HIPAA REQUIREMENT

This section is **REQUIRED** for the treatment of ALL (Adult & Minor) patients

Please list names of any person who may have access to patient's information.

Name: _____________________________________ Relationship to Patient: ________________________________

Date of Birth: _____/_____/_________ Phone Number: _____________________________________

Name: _____________________________________ Relationship to Patient: ________________________________

Date of Birth: _____/_____/_________ Phone Number: _____________________________________

Name: _____________________________________ Relationship to Patient: ________________________________

Date of Birth: _____/_____/_________ Phone Number: _____________________________________

New Patient Information

Mailing Address: ____

City: ____ State: _______________ Zip Code: __________________

Age: _____________ SSN: _______-_______-________ Gender: Male Female

Marital Status: Single Married Divorced Widowed

Employer: _____________________________ Employer Address: ____

Insurance Information

Primary Insurance Provider: _____________________________ Policy Holder's Name: ___________________________

Policy Holder's DOB: _____/_____/_______

Secondary Insurance Provider: ___________________________ Policy Holder's Name: ___________________________

Policy Holder's DOB: _____/_____/_______

Signature: ____ Date: ___________________________

PATIENT FINANCIAL POLICY

Thank you for choosing Heritage Urgent & Primary Care. While your health and well-being is our primary concern, we realize that the cost of healthcare is an issue for many patients. We offer the following information to help you understand our financial policies and aid you in planning for payment. Carefully review the information and please ask our staff if you have any questions.

INSURANCE

It is your responsibility to provide Heritage Urgent & Primary Care with current insurance information. We will ask you for your insurance card at your first visit and keep a copy for your records. We may request a copy at a later date in order to update your records, so please bring your insurance card to each visit. We will help you receive the maximum benefits your insurance allows, however, please remember that your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your claims for you and provide necessary information, including primary and secondary insurance information changes, to your insurance company. Failure to provide complete insurance information may results in reduced insurance benefits for you.

Not all services are covered through all insurance plans. Some health plans select certain services that they will cover. Your insurance company will make the final determination of your eligibility and benefits. In the even that your health plan determines a service to be “not covered”, you will be responsible for the entire charge. Also, please be aware that if we are out-of-network for benefits, you will receive a bill and be responsible for the remaining balance. This balance is due upon receipt of your statement. In the event that you are unable to pay the balance in full, we encourage you to promptly contact our billing office at 866-557-2612 for assistance in creating a payment plan. Be aware that if your treatment requires biopsy or culture, you may receive a bill from a third party.

CO-PAYS

Co-payments may be required by your insurance plan. All co-payments must be paid prior to your appointment at check in. If you do not have your co-payment, your appointment may be rescheduled.

DEDUCTIBLES AND COINSURANCE

For patients who have insurance plans that have applicable deductibles and coinsurance, be aware that you will be responsible for payment of the deductible or coinsurance applicable to procedures. It is also the patient’s responsibility to check with insurance carrier concerning deductibles and coinsurance.

SELF-PAY ACCOUNTS

Self-pay accounts are for patients without insurance coverage. It may also include patients covered by insurance plans that Heritage Urgent & Primary Care is not in network with or patients without an insurance card on file. It is your responsibility to know if care at Heritage Urgent & Primary Care is covered by your plan. If there is a discrepancy of your information, you will be considered a self-pay patient until you provide information proving otherwise.

PAST DUE ACCOUNTS

If your account is part due, please contact the billing office at 866-557-2612, so that we can assist you with a payment plan. If your account has been referred to a collection agency or attorney, you must pay the balance in full, including any collection fees. If you require further treatment and your account is in collections, the full balance will be due, and you will be required to pay the cost of the next visit in full, prior to being seen.

RETURNED CHECKS

A fee may be required for returned checks. This amount will be applied to your account, in addition to the insufficient funds amount. Your account may be assigned “self-pay” status, requiring upfront payments following a returned check.

REFERRALS & PRE-AUTHORIZATIONS/NOTIFICATIONS/CERTIFICATES

Your insurance company may require a referral from another physician and/or a pre-authorization, notification, or certification. While it is your responsibility to obtain these, someone in the office will help you if necessary. Please make sure that all referrals are in our office prior to your visit. Failure to obtain these may result in a lower payment or no payment from your insurance company, and the balance will be your responsibility.

MINORS

The parent(s) or guardian(s) presenting the child for treatment is responsible for full payment and will receive the billing statements. In addition, we may pursue payment from a non-custodial parent of guardian.

PATIENT AUTHORIZATION, ACKNOWLEDGEMENT, AND AGREEMENT

I hereby authorize payment of health insurance benefits and, if applicable, government benefits directly to Heritage Urgent & Primary Care for services provided to me. I authorize the release of my healthcare information necessary to process my claims. I further authorize the release of my healthcare information to other healthcare providers, hospitals, and facilities involved in my treatment.

I understand, acknowledge, and agree that I am financially responsible for my deductible, co-pay, coinsurance, and any amount exceeding what my insurance company pays, except where exempt by contractual agreement. I understand that I am financially responsible for any balance remaining after my claim has been processed. I further upstand that I am responsible for complying with any requirements that my insurance carrier may have regarding referrals, prior approvals, and pre-authorizations.

I HAVE READ THE PATIENT FINANCIAL POLICY AND/OR IT HAS BEEN FULLY ERXPLAINED TO ME. I CERTIFY THAT I UNDERSTAND ITS CONTENTS, AND THATI AM COMPETENT TO EXECUTE IT OR THAT I AM AUTHORIZED TO EXECUTE IT ON THE PATIENT’S BEHALF.

Print Patient’s Name: ____

Signature: ____ Date: ___________________

Parent/Guardian Name (if applicable): ____

Parent/Guardian Signature: ____

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been offered or received a copy of Heritage Urgent and Primary Care's NOTICE OF PRIMARY PRACTICES. I understand that Heritage Urgent & Primary Care is a healthcare provider and may share my health information for treatment, payment, and healthcare operations. I understand that if I have questions of concerns regarding my privacy rights, I may send correspondence in writing or by phone to:

Raleigh Durham Medical Group 5420 Wade Park Blvd, Suite 106 Raleigh, NC 27607-4189
P: 919-782-1806

PLEASE NOTE: ALL COMPLAINTS MUST BE IN WRITING

I further understand that if the NOTE OF PRIVACY PRACTICES should be amended, modified, or changed, I will be notified at my next visit.

Patient OR Guardian Signature: ____ Date: ___________________

CANCELLATION AND NO SHOW POLICY

We understand that situation arise that may require cancellation of your appointment. It is therefore requested that if you must cancel, please give us a 24-hour notice. This will enable other patients who are waiting for appointments to be scheduled in your slot.

Appointments that are cancelled with less than a 24-hour notification may be subject to a $35 cancellation fee.

Patient who do not show up for their scheduled appointment without a 24-hour cancellation notice are considered a NO SHOW and will be charged at $35 NO SHOW fee.

The cancellation and NO SHOW fees are the sole responsibility of the patient and must be paid in full before the patient can be seen again.

We understand that special circumstances may arise and cause you to cancel with less than a 24-hour notification. In this case, the cancellation fee MAY be waived by management approval.

Heritage Urgent & Primary Care believes that a good provider/patient relationship is based upon understanding and communication. Please sign below that you have read, understand, and agree to our Cancellation and No Show Policy.

Patient OR Guardian Signature: ____ Date: ___________________

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ____ Date of Birth: __________________________________

Social Security #: ____________-________-____________

I request and authorize Heritage Urgent & Primary Care to release healthcare information of the patient name above to:

Name: ______________________________________ Address: ____
(Doctor's/Practice Name)

I request and authorize __________________________________ to release healthcare information of the patient name above to:
(Doctor's/Practice Name)

Heritage Urgent & Primary Care   Wake Forest   Raleigh

This request and authorization applies to all:

Healthcare information relating to the following treatment, condition, or dates: ____

All healthcare Information

Other: ____

Purpose or Need for the Disclosure is:

Continued Medical Care   Insurance   Legal   Patient's own use   Other: ___________________________

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No   I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No   I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Fees: I understand and agree that there may be costs associated with this request in compliance with State copying laws.

Patient Signature: ____ Date: ______________________________

Wake Forest
620 Dr. Calvin Jones Hwy., #212
Wake Forest, NC 27587
P: 919.761.5678
F: 919.761.5680

Leesville
13271 Strickland Rd. #120
Raleigh, NC 27613
P: 919.741.4677
F: 919.741.6349

heritage URGENT & PRIMARY CARE

Health History Questionnaire

Name: ____ Date of Birth: ____________________

Please describe what problem or concern brought you to our office today:

Primarily to establish care

Other (please briefly describe): ____

Pharmacy (Name and Location) ____

Do you authorize Heritage Urgent & Primary Care to leave health information on your voicemail? Yes No

Do you have a Primary Care Provider? Yes No If yes: Have you seen the provider in the past year? Yes No

Name & Location of Primary Care Provider: ____

Special Communication Needs

Language preference:					
If 'yes' to any of the question below, how can we assist?					
Visual Impairment	Yes	No	Cognitive Impairment	Yes	No
Hearing Impairment	Yes	No	Sensory Impairment	Yes	No
Speech Impairment	Yes	No	Other:		

Personal Health History

Please check past or current problems or conditions

Condition	Condition
Hypertension	Seizures
High Cholesterol	Headaches
Diabetes	Stroke
Heart attack or angina	Prostate problem
Irregular heart rhythm	Breast problem
Congestive heart failure	Urinary tract infections
Asthma	Osteoarthritis
Emphysema or chronic bronchitis	Cancer (Please List type)
Pneumonia	Thyroid problem
Gastroesophageal reflux disease	Bleeding disorder
Stomach ulcer	Addiction Issues
Kidney problems	Depression or anxiety
Liver disease/Hepatitis	Mental Illness
Colon cancer	Other (please describe)
Bowel/Digestive problem	

Previous Surgical Procedures

Check if you have any of the following

Procedure	Year
Heart surgery	
Carotid artery surgery	
Vascular surgery / stent	
Abdominal aneurysm repair	
Hysterectomy	
Gallbladder removal	
Appendix removal	
Tonsillectomy	
Joint replacement	
Breast cancer surgery	
Prostate cancer surgery	
Hernia	
Pacemaker	
Other (Please describe)	

Allergies:

Please List any allergies to medications or foods	

Current Health Concerns

Please check problems or conditions that you are <u>CURRENTLY EXPERIENCING</u>

Chest pain	Rectal bleeding	Eye pain	Nervousness
Shortness of breath	Black/tarry stools	Loss of vision	Pain in testicles
Wheezing	Weight loss	Double vision	Loss of libido
Cough	Weight gain	Memory loss	Impotence
Coughing up blood	Loss of appetite	Ringing in ears	Breast pain
Sore throat	Difficulty swallowing	Pain in ears	Breast discharge
Nasal congestion	Diarrhea	Nose bleeds	Other (Please describe below)
Irregular heartbeat	Constipation	Hoarseness	
Fast heartbeat	Painful urination	Easy bleeding	
High blood pressure	Blood in urine	Easy bruising	
Low blood pressure	Urine frequency	Rash	
Lightheadedness	Decrease in urine flow	Changes in mole	
Dizziness / Fainting	Urine leakage	Sore that won't heal	
Abdominal pain	Headache	Fatigue / Lethargy	
Heartburn	Weakness	Insomnia	
Indigestion	Loss of strength	Forgetfulness	
Ankle swelling	Balance problems	Depression	
Nausea			
Vomiting			
Vomiting blood			
Change in bowel habits			

Pain, Weakness, or Numbness in:		
Arms	Hips	Back
Legs	Neck	Shoulders
Hands	Feet	

FEMALES – PLEASE COMPLETE
Menstrual flow: Reg. Irreg. Pain/cramps
Days of flow ___ Length of cycle ___
1st day of last period _____________
Pain or bleeding after sex
Number of pregnancies _____
Miscarriages _____
Birth control method _____________

Medications

Please list all medications that you take including over the counter medications, herbs, and supplements.
(Please include dose and frequency)

Patient Signature: ____ Date: ____________________________

Family History

Relationship	Living Y / N	Age	Major Medical Problems and / or Cause of Death
Father			
Mother			
Siblings			
Children			

Specifically have any of your relatives had the following conditions

Condition	Relative	Condition	Relative
Mental Illness		Chemical dependency	

Health Maintenance

Please check whether you have had the following preventive services and enter the year of the service

Immunizations		Year	Tests		Year
Tetanus vaccine / Tdap	Yes No		Pap Smear / Pelvic	Yes No	
Pneumonia vaccine	Yes No		Mammogram	Yes No	
Influenza vaccine	Yes No		Bone dexa	Yes No	
Shingles vaccine	Yes No		Colonoscopy	Yes No	
			Prostate test	Yes No	

Specialty Providers

Please list any medical providers you see outside of this practice and list the year that you last saw them

Eye doctor	Nephrologist
Cardiologist	Psychiatrist
Oncologist	Allergist
Urologist / Gynecologist	Vascular
Gastroenterologist	Pulmonologist
Endocrinologist	Other

Advance Care Planning

Do you currently have or would you like information on Any of the following items

Living Will Have Don't have Want Information
Durable Power of Attorney Have Don't have Want information
DNR Order Have Don't have Want information
Other

Social History

Please circle appropriate answers below and provide explanations where appropriate

Marital Status: Single Married Divorced Widowed Life Partner

Education lever: Did not Graduate High School Some College Bachelor's Degree Master's Degree or Higher

Occupation:

Occupational concerns: Stress Hazardous substances Heavy lifting

How stressful would you rate your current living situation:(Circle number) No stress 1 2 3 4 5 6 7 8 9 10 Very Stressful

Are there financial concerns that affect your ability to seek healthcare? No Yes If yes, describe below

Are there any religious or cultural factors that you would like us to take into account when planning your healthcare?

Fall Risk Screening

In the last 12 months have you fallen?	Yes	No	Unsure		
If yes, How many times?	1	2	3	4	5+
Where you injured as a result of the fall?	Yes	No	Unsure		

Health Behaviors

Tobacco Use:	Never	Quit (when) ___________	Current smoker
If current smoker how many packs per day ___________	How many years ___________		
Alcohol intake:	No	Yes	If Yes, how many drinks / how often ___________________________
Illicit drug use (Including marijuana, cocaine, steroids):	Never	Past	Current
If past or current drug use please describe:			

Exposure to secondhand smoke	Yes	No	Wear a seatbelt	Yes	No
Eat a diet high in fruits and vegetables	Yes	No	See a dentist at least once a year	Yes	No
Get 30 minutes of exercise 5x per week	Yes	No	Wear sunscreen	Yes	No

Mood Screening

A person's mood can have a strong influence on their health status and overall wellbeing.
Over the past 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things	Feeling down, depressed, or hopeless
Not at all	Not at all
Several days	Several days
More than half the days	More than half the days
Nearly every day	Nearly every day

Urinary Incontinence Assessment

Do you experience leaking in the following situation?	Not at all	A little	Sometimes	A lot
During daily activities (work, household task)				
During physical activities (walking, swimming, or other exercise)				
During recreational activities (movies, hobbies)				
During social activities (going out with friends, family visits)				
During car trips				
In the past few weeks:	Not at all	A little	Sometimes	A lot
Have you frequently experienced the need to urinate?				
Have you experienced leaking before an urgent need to urinate?				
Have you experienced leaking on effort, such as when sneezing, coughing, jumping, laughing, or during physical activity?				
Have you experienced a pressing or immediate urge to urinate?				
Have you noticed a change in your urination frequency?				
Do you need to urinate more then 8 times every 24 hours?				
Do you have to get up more than twice during the night to urinate?				
Do you sometimes have to strain to urinate?				

Health Literacy Questionnaire

Many times in healthcare staff and providers use words that are unfamiliar to the general population.
Please rate the following questions on a scale of 1 to 10

I feel that I have a thorough understanding of the instructions That my doctor and nurses give me about my health	1 2 3 4 5 6 7 8 9 10 Strongly Disagree … Strongly Agree
I feel that I remember the instructions given to me at my doctor's office when I get home	1 2 3 4 5 6 7 8 9 10 Strongly Disagree … Strongly Agree
I feel that I have a strong understanding of medical language	1 2 3 4 5 6 7 8 9 10 Strongly Disagree … Strongly Agree