NORTH BUNCOMBE FAMILY MEDICINE, PA

Patient Name: _____

Address: _____ City:____ State: _____ Zip: _____

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

Date of Birth: _____/_____/_____ SS#: _____-_____-_____ Sex: M / F

Marital Status: _____ Email Address: _____

Race: _____ Preferred Language: _____ Ethnicity: (circle one): Non Hispanic/Non Latino Hispanic/Latino

Is the patient a minor? **Y/N If so, who is the guarantor: _____Guarantor SS# & DOB: _____

Employment Status: (circle one): Full-time Part-time Unemployed Self-employed Retired Student None

Name of Insurance Carrier: _____
Insurance Subscribers Name: (if different from patient): _____
Insurance Subscribers Date of Birth: _____/_____/_____ Insurance Subscribers SS#: _____-_____-_____
Insurance Subscriber Address: (if different from patient): _____

In case of emergency, contact: _____ Relationship: _____ Phone: _____

How did you hear about North Buncombe Family Medicine, P.A.?_____

Please list any family or friends with whom we can discuss your general health if you are unavailable. This does not include detailed medical information and/or lab results. Additional authorization is required.

_____

Assignment of Benefits
I hereby authorize payment of contracted insurance, Medicaid and/or Medicare benefits directly to North Buncombe Family Medicine, P.A. and I authorize them to file insurance on my behalf. I also authorize them to release medical and/or account information to my insurance, Medicaid and/or Medicare carrier as required to satisfy claims.
I understand that North Buncombe Family Medicine, P.A.

- Expects payment on the date of service. If insured by a contracted carrier, co-pays and deductibles are expected prior to your appointment.
- Accepts Medicaid, Medicare and all insurance and will file claims for me. However, it is my responsibility to know the details of my insurance coverage and provide North Buncombe Family Medicine, P.A. with current and accurate information.
- Provides services and treatment, which are medically appropriate. However, some of these may not be covered by my insurance plan and these will be my responsibility to pay.
- Expects the parent or guardian to pay for all services rendered to their dependents.

Consent for Treatment
I hereby consent to medical treatment(s) and diagnostic lab(s). I understand I have the right to ask questions about my treatment and/or procedures and I agree to notify my provider of my concerns.

Notice of Privacy Practices Acknowledgement
I have been provided a copy of North Buncombe Family Medicine, P.A., **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law.

Patient or Legal Guardian Signature: _____Date: _____

(over)

North Buncombe Family Medicine, P.A.

Patient Financial Policy

To our patients: Welcome to our practice! We are very happy to have you as a patient.

Patient Financial Class Policies: You will be required to provide current insurance information at every visit and as needed throughout your care. Benefits and eligibility are verified prior to every visit. Payment is collected based on your benefits and eligibility at the time of service. Co-pays, coinsurance, deductibles and balances due will be collected in full at the time of service. We do not bill any patient portion of the visit.

Self Pay: Payment in full is due at the time of service and no payment plan or billing options are available. We offer a 20% discount when payment is received at time of service.

Commercial Insurance Carriers: We file most insurance carriers for you as long as current insurance information is provided to us. Any outstanding balances and co-payments are due prior to checking in for your appointment. If you have a deductible and/or coinsurance with your insurance carrier, we will collect your estimated portion at the end of the visit. You will be required to pay these amounts when you check out. We do not bill your estimated portion of the visit. Since your agreement with your insurance carrier is private, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If your insurance carrier has not paid within 30 days of the date of service or if they do not cover your visit completely, you will be billed and payment is due in full immediately.

Our office will file claims to non-participating insurance carriers. However, we require payment in full at the time of service from patients whose insurance is considered an out-of-network insurance carrier. Any payable benefits will be paid directly to you once the claim is filed by our office.

Medicare: Our office is a Medicare participating provider and will bill Medicare for you. If you have insurance secondary to Medicare, we will bill it for you. In the event that you do not have secondary insurance or your secondary insurance carrier does not cover your Medicare deductible or coinsurance, you will be required to pay any patient portions of the visit.

Medicaid: Our office is a Medicaid participating provider. We will bill Medicaid for you. Co-pays are due when you check in for your appointment. If you are Medicaid-Carolina Access, our practice name is required on your Medicaid card. We do not accept Medicaid-Carolina Access that is assigned to another practice.

Worker's Compensation: If your visit is work-related we will need the carrier name, contact person, telephone number & case number prior to your visit in order to bill the worker's compensation insurance company. Worker's Comp must be verified and approved prior to your visit.

Auto/Other Policy: If your visit is related to an automobile accident or injury/illness related to an accident, we will collect payment in full at the time of service. You will need to file your claim with the carrier involved in the accident/injury.

In Conclusion: Our office accepts cash, personal check and debt/credit cards (Visa, MasterCard & Discover).

For returned checks we assess a $25.00 return check fee, any applicable bank fees, and report to the local district attorney's office checks that are not paid within 2 weeks of being returned to our office.

If not paid according to these terms, you understand that our office reports to an outside collection agency. In the event that your account is turned over for collections you agree to pay all additional fees accessed in the collection of the debt. These fees include collection agency fees and attorney fees. **Unpaid accounts may also result in dismissal from our practice for the patient and their immediate family members.**

Our office adheres strictly to national billing and coding guidelines. We must bill your insurance company for all care that is provided. We cannot change a diagnosis or a procedure code so that your insurance will pay more of the bill. It's illegal.

Our office files insurance as a courtesy. The patient is ultimately responsible for all fees for services. I have read, understand and agree to the above financial policy for payments of professional services and fees.

Patients Name (Please Print): _____ **Date of Birth:** _____

Signature: _____ **Social Security # of Responsible Party:** _____ **Date:** _____

(Person who is financially responsible) **(Required)**

North Buncombe Family Medicine, PA

Patient/Provider Agreement

Thank you for choosing North Buncombe Family Medicine, P.A. (NBFM) for your primary care needs. Our practice is dedicated to providing a high quality of healthcare and has set policies to ensure that we accomplish and maintain that goal. This Patient/Provider agreement has been prepared to better inform you with our office policies.

Appointment Policy
It is our policy that any appointments that you are unable to keep require a 24 hour notice. If we are not notified within 24 hours that you are not able to keep your appointment, we consider this a missed appointment. We do understand that emergencies happen and will address these issues as necessary.

When patients fail to keep their appointment, it results in a violation of our policies and procedures. Therefore, **failure to notify our practice that you can not keep an appointment may result in dismissal from our practice.**

A $25.00 fee may be assessed to appointments that are missed or not canceled at least 24 hours in advance.

Hospital Admissions
To assure quality inpatient care for you and your family, our physicians have made arrangements with two groups to assist with our patients who require admission and in-patient care at Mission Hospitals.

Asheville Hospitalist Group (AHG) is part of Mission Medical Associates, a physician group practice of Mission Health System. They provide 24/7 adult inpatient care at Mission Hospital and have built strong relationships with their fellow community and regional physicians. AHG will care for our adult patients.

Mountain Area Family Health Center (MAHEC) is a local group of licensed resident and faculty physicians. They provide 24/7 inpatient care at Mission Hospital and have also built strong relationships with their fellow community and regional physicians. MAHEC will care for our newborn and pediatric patients.

Please be assured that there will be ongoing communication between your physician at North Buncombe Family Medicine, P.A. and the physicians at MAHEC and AHG proving your care during your hospitalization.

Prescriptions
Your physician will need a list of all of your current medications at your initial appointment.

- All prescription refill request require a 24 hour notice.
- We cannot prescribe an antibiotic over the telephone. You will need to be seen by a physician before an antibiotic can be prescribed.
- We cannot refill a prescription unless you have been seen within the last twelve months.
- The on-call physician will not refill any prescriptions after hours, including, weekends and holidays.

Controlled Substance (Narcotic) Prescriptions
The physician treating you **may** prescribe a federally-controlled substance to help with your symptoms. Because these medications can be abused, we have the following guidelines for their use.

Our policy requires that you treat these medications with great respect and keep them secure.

- They should not be left where children can find them.
- They should not be left in any public place.
- They should never be shared with another person.
- They should be taken only as the bottle directions state.

Our physicians will exert firm control over prescribing these medications.

- A new prescription will not be written if your medication is lost or stolen.
- No refills will be written if you over-use the medication (based on the bottle instructions).
- It is our general policy not to refill narcotic prescriptions without a recheck visit.

Any evidence of misuse of these medications will prompt action on our part.

- At the very least, any evidence of misuse will mean that no further controlled substances will be prescribed for you.
- Altered prescriptions or evidence of "doctor-shopping" or apparent fraud in obtaining these medications will lead to contact with law enforcement agencies.
- Any violations can result in immediate dismissal from our practice.

Attention: **If you are currently taking a narcotic that has been prescribed by another physician, please let us know immediately. Our physicians may not be able to maintain or continue these prescriptions.**

Conclusion
We strive to provide the highest quality of healthcare. Please feel free to ask one of our staff members any questions you may have. We are here to help you and take care of you. In exchange, we ask that you treat our staff with respect at all times.

I have received and read the Patient/Provider Agreement and agree to abide by these guidelines.

Patients Name (Please Print): _____ **Date of Birth:** _____

Signature: _____ **Date:** _____
(Patient or Legal Guardian)

NORTH BUNCOMBE FAMILY MEDICINE, PA RELEASE OF MEDICAL INFORMATION

PLEASE PRINT YOUR NAME: _____

BY SIGNING BELOW, I AUTHORIZE North Buncombe Family Medicine, PA TO RELEASE MY MEDICAL AND BILLING INFORMATION TO:

RELATIONSHIP			NAME OF DESIGNATED PERSON
SPOUSE	☐ YES	☐ NO	_____
CHILDREN	☐ YES	☐ NO	_____
IN-LAWS	☐ YES	☐ NO	_____
CAREGIVERS	☐ YES	☐ NO	_____
PARENTS	☐ YES	☐ NO	_____

OTHERS _____

PATIENT SIGNATURE _____ DATE _____

PARENT SIGNATURE _____ DATE _____

We ask if you have any change in this request that you please inform the receptionist.

North Buncombe Family Medicine, PA MAY LEAVE APPOINTMENT INFORMATION ON MY VOICEMAIL:

HOME	☐ YES	☐ NO
WORK	☐ YES	☐ NO
RELATIVE	☐ YES	☐ NO

PATIENT SIGNATURE _____

I AUTHORIZE THE FOLLOWING TO PICK UP PRESCRIPTIONS, X-RAYS, ETC....

RELATIONSHIP			
SPOUSE	☐ YES	☐ NO	_____
RELATIVE	☐ YES	☐ NO	_____
CAREGIVER	☐ YES	☐ NO	_____

PATIENT SIGNATURE _____ DATE _____

I UNDERSTAND THAT THE NORTH BUNCOMBE FAMILY MEDICINE, PA WILL ASK FOR IDENTIFICATION OF THE PERSON PICKING UP PATIENT MEDICAL INFORMATION OR PRODUCTS.

NORTH BUNCOMBE FAMILY MEDICINE, PA

FollowMyHealth Patient Registration Proxy Form

By accepting the Proxy invitation to the Patient Portal, you will be able to:

- View the Minor Patients Health Summary
- Send and Receive Messages through their Inbox
- Review Lab Results
- Review Recent Visits
- Schedule an Appointment
- View Upcoming Appointments
- Print the Minor Patients Immunization Record
- Update the Information of the Minor Patient

Patient Name: _____ Date of Birth: _____

Guarantor's Name: _____

Guarantor's Address: _____

Guarantor's Telephone Number: _____

Guarantor's Email Address: _____

Relationship to the Minor Patient: _____

_____ **YES**, I would like to accept a Proxy invitation to the Patient Portal.

_____ **NO** – Reason: _____

By declining, I understand I will not have access to the information in the Patient Portal.

We want to thank you for your interest in the Patient Portal. You will receive an email with the invitation to activate your account. Please activate your account within 30 days.

For Office Use Only:

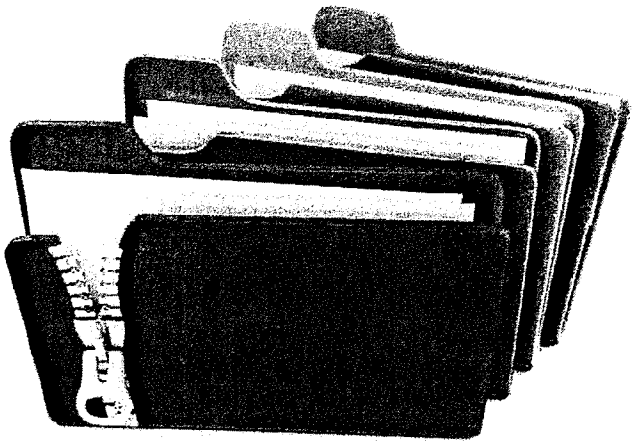
Registered by _____ Pt Portal Invite _____

Pt Portal Active _____ Pt Portal Refused _____ EHR Updated _____

Completed by _____

North Buncombe Family Medicine,PA

201 Flat Creek Village Dr.
Weaverville, NC 28787
www.northbuncombefamilymedicine.com
Telephone #: 828-645-8525
Privacy Official: Nikki Daves



Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

continued on next page

Your Rights *continued*

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
	  • We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  • We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	*Example: We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	*Example: We give information about you to your health insurance plan so it will pay for your services.*

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How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date: September 23, 2013
Revision Date: March 15, 2018

This Notice of Privacy Practices applies to the following organizations.

This notice also applies to the health care providers, such as physicians and/or thier staffs, who are not employed by North Buncombe Family Medicine, PA but participate in the Mission Health Partners network or Accountable Care Organization (ACO), to provide this care along with North Buncombe Family Medicine, PA through an "organized health care arrangement" under HIPAA. All of these care providers are also referred to as "we" in this Notice.

Privacy Official, Nikki Daves, email: nbfmpracticemanager@gmail.com, telephone #:828-645-8525

North Buncombe Family Medicine, PA

This form helps us review and understand your health.
(**Pediatric** ages 0-16 yrs)

Patient Name: _____

Patient Date of Birth: _____

Parent/Guardian Name: _____ Single _____ Married _____

Maiden Name of Child's Mother: _____

1. Please list current and past doctors: (address and phone number if possible)
   _____
   _____
2. Do you have any concerns about your Child's Health? Please describe:
   _____
   _____
3. Please list any medical conditions patient has:
   _____
   _____
4. Pleasc list any allergies to medications:
   _____
   _____
5. List all other allergies? (Bee stings, etc.)
   _____
   _____
6. List all current medications:
   _____
   _____

Birth History if LESS THAN 5 yrs old.

Birth Weight:_____ Birth Length:_____

Delivery: Vaginal C-Section Why?_____

Full-term Born Early Born @ how many weeks:_____

Any complications during pregnancy?_____

Any complications with delivery?_____

7. Identify immunizations given and list year: (copy of Immunization records)

Immunizations	Date	Immunizations	Date
Tetanus (Dtap or Tdap)		Varicella (chicken Pox)	
Hib (all types)		PCV (pneumonia)	
IPV (polio)		MCV (meningitis)	
MMR (measles)		HPV (human papillo)	
Hep B		Flu	
Hep A		Others:	

8. Please list any medical condition that runs in your family: (heart, blood pressure, thyroid, cancer, asthma, lung disease, diabetes, etc)

   Mom_____ Dad_____

   Siblings_____ _____ Grandparents_____

9. Please list any Hospitalizations, ER visits, and/or Surgeries:

   _____

   _____

10. Who lives in the house with the child?_____

11. Besides you, who else takes care of child?_____

12. How often does your child use a seatbelt/car seat?_____

13. Does your child ride a bicycle?_____ Use a helmet_____

14. In the past year, have you or child felt threatened at home?_____

15. What kind of guns are in your home?_____
    Are they locked?_____ _____

16. Does anyone in household smoke? _____ Inside or Outside? _____

17. Do you have active smoke detectors in home? _____

18. If child is an infant/toddler, do you have safety locks & protectors on appropriate cabinets/doors/wall plugs?_____

_____

19. What is the child's regular bedtime?_____ Routine_____

20. How docs child interact with peers?_____ At School?_____

_____

_____

Please mark the box if you suffer from any of the conditions listed below:

GENERAL
- o Weight gain
- o Weight loss
- o Fevers
- o Tiredness/fatigue

RESPIRATORY
- o Wheezing
- o Coughing
- o Coughing up phlegm
- o Difficulty breathing

GATROINTESTINAL
- o Choking/gagging with food
- o Vomiting
- o Heartburn
- o Diarrhea
- o Constipation
- o Abdominal pain
- o Rectal bleeding

CARDIOVASCULAR
- o Chest pain
- o Irregular heart beat
- o Heart murmur
- o Swelling of extremities

ALLERGY
- o Seasonal runny nose
- o Watery eyes
- o Nasal congestion
- o Sneezing

SKIN
- o Eczema
- o Rashes
- o Itching
- o Birthmarks
- o New lesions

EARS/ NOSE/ THROAT
- o Earache/pain
- o Hearing loss
- o Nosebleeds
- o Hoarseness
- o Sore throat
- o Swollen glands

EYES
- o Glasses/contacts
- o Eye pain
- o Eye redness
- o Blurred vision

GENITOURINARY
- o Pain with urination
- o Blood in urine
- o Menstrual problems

ENDOCRINE
- o Heat / cold intolerance
- o Diabetes
- o Excessive sweats
- o Excessive thirst
- o Excessive urination

NEUROLOGICAL
- o Headache
- o Seizures
- o Dizziness
- o Weakness
- o School problems
- o Speech problems

MUSCULOSKELETAL
- o Joint pain/stiffness
- o Muscle pain/swelling
- o Back pain
- o Neck pain

PSYCHIATRIC
- o Mood swings
- o Attention deficit
- o Depression
- o Anxiety
- o Nervousness
- o Anger/outburst