ADULT INTERNAL MEDICINE
AIM for Excellence in Health

MDVIP

Date: _____

REGISTRATION SHEET

Patient Information

First _____ Middle_____ Last _____ Nickname_____

Address _____

City _____ State _____ Zip _____

Home Phone # ( ) _____ Work Phone # ( )_____ ext._____

Cell Phone # ( ) _____ Preferred Language English ___Spanish____other_____

Email address: _____

Date of Birth: _____/_____/_____ Sex: ☐ Male ☐ Female Social Security #: _____-_____-_____

Marital Status S M W D Spouse Name: _____

Driver's License #_____ State: _____ If other than North Carolina

Ethnicity: □ African-American □ American Indian □ Asian □ Caucasian □ Hispanic □ Other _____

Insurance Name:_____ Policy #:_____ Group #: _____

Benefits and Eligibility or Customer Service Telephone # (located on your insurance card): (_____)_____

Other Information

How did you get referred to our clinic: _____

If the insurance policy is held by someone other than yourself please enter information below.

Guarantor Last Name _____ First Name _____ M.I. _____

Address _____ City _____ State _____ Zip _____

Employer _____ Work # ( ) _____ Home # ( ) _____

Social Security # _____ Date of Birth _____Relationship to Patient _____

Emergency Contact

Person to Contact Other than Spouse _____ Phone # ( ) _____

Relationship to Patient _____

Advance Directives

Do you have a Living Will or an Advanced Directives document? □Yes □ No

If not, our staff will be glad to provide you with information. If you have a Living Will or Advanced Directives documents, please submit a copy to this office for our records.

Messages

May we leave messages related to your care with family, friends, or on answering machine? □ Yes □ No

Policies and Consents

I. Consent to Medical Treatment

I voluntarily consent to such diagnostic procedures and care deemed necessary by my health care provider, his or her assistant(s) or designated consultants. I understand the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the result of examination or treatment in this clinic.

I understand that annual physical exams are necessary to supply my health care provider with important information on my health status. I further understand that the performance of annual physical exams is required by Adult Internal Medicine and I consent to this treatment plan. I agree that if my health care benefits do not include annual physical exams I will be responsible for payment of these fees.

I understand that together my health care provider and I will develop a treatment plan that is best for my health care. I further understand that if I make any changes to my treatment plan without first consulting my health care provider I may jeopardize my health care. I agree to follow the guidelines and treatment plan that my health care provider and I have developed. I understand that if I choose to not to follow this treatment plan then either myself or my health care provider reserves the right to terminate our provider / patient relationship.

II. Authorizations

Authorization to Release Information: The undersigned hereby authorizes said Provider to release all information pertaining to the patient's treatment to his/her insurance company or companies and to any other physician or health care provider to whom the undersigned may be referred.

Assignment of Benefits: I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicaid, private insurance, and other health plans to Adult Internal Medicine, P.A.

III. Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **Adult Internal Medicine, P.A.** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by **Adult Internal Medicine, P.A.** describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Adult Internal Medicine, P.A.** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the privacy officer at:

_____

Adult Internal Medicine, P.A.
Post Office Box 3363
Hickory, North Carolina 28603

This consent allows **Adult Internal Medicine, P.A.** to call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory tests results, among others.

This consent allows **Adult Internal Medicine, P.A.** to mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

This consent allows **Adult Internal Medicine, P.A.** to email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that **Adult Internal Medicine, P.A.** restrict how it uses and discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Adult Internal Medicine, P.A.** to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or if I later revoke it, **Adult Internal Medicine, P.A.** may decline to provide treatment to me. Also, I acknowledge that I have been given the opportunity to receive a full disclosure of the Privacy Practices as outlined by the Health Insurance Portability and Accountability Act of 1996.

IV. Financial Policy

FULL PAYMENT IS DUE AT THE TIME OF SERVICE.

For your convenience WE ACCEPT: Cash, Check, Visa, MasterCard, Discovery

Regarding Insurance

Please understand that payment of the bill is your responsibility**.** ***We only file insurance claims for those insurance plans with whom we participate***. In order for us to bill your insurance company, you must provide a current copy(s) of your insurance card(s). If you cannot provide a current copy of your insurance card, **payment in full** is expected **at the time of service** and you will be responsible for filing the claim to receive payment directly from your insurance company. **We cannot file claims retrospectively**. Once we are able to validate your insurance coverage we will file your insurance claims.

Secondary or Supplemental Insurance Coverage

Commercial Insurance Plans

We will only file secondary insurance claims for the companies with whom we participate. If we do not participate with your secondary insurance company it is your responsibility to file the insurance claims and you will be responsible for any copayments, coinsurances, and/or deductibles that are not covered by your primary insurance plan at the time of services. Any unpaid balances over 30 days old will be assessed monthly a $5.00 late payment fee.

Medicare

If you have Medicare and your supplement plan is a complimentary crossover or a medigap policy, Medicare automatically files the claim to your supplemental policy. If your Medicare supplemental policy is not automatically filed by Medicare and/or is not a plan in which we participate you will be responsible for payment of copayments, coinsurances, and/or deductibles at the time of service and you will be responsible for filing your own claims.

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All co-payments, coinsurance and deductibles are due on the day of service. The balance is your responsibility whether the insurance company pays or does not pay. Any unpaid balances over 30 days old will be assessed monthly a $5.00 late payment fee.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We are unable to make determination of your benefits. This information can only be provided by your insurance company.

We participate with a number of insurance plans and accept assignment of benefits on those plans. For those plans we file insurance claims. If you are unsure if we participate with your particular plan please feel free to ask a staff member.

If we are not a participating provider with your insurance company you will be responsible for filing your own insurance claims. **Full payment is required at the time of visit**. Your insurance company will reimburse you directly.

Non-covered Services and Medical Necessity Guidelines

Each insurance plan is unique and offers a variety of benefit plans. *(If you are unaware of your benefits please call the customer service number on the back of your insurance card*.) Please be aware that some, and perhaps all, services provided may be non-covered services or not considered medically necessary by your insurance plan therefore not considered *reasonable and/or medically necessary*. However, your physician may feel that these services are important to your health care. In the event your insurance company denies a claim as non-covered or as not meeting medical necessity guidelines you will be responsible for payment in full for these services. **You are responsible for knowing your health plan policies.**

Usual and Customary Rates

Our practice is committed to providing quality care for our patients and we charge what is usual and customary for your area. You are responsible for payment regardless of any insurance company's determination of usual and customary rates.

Missed Appointments

Unless cancelled at least 24 hours in advance, there is a **$30.00 charge** for missed appointments or for same day work-in appointments that are not kept. This $30 charge is not payable by your health plan. No show or cancellation fees must be paid prior to, or on the same day of, your next appointment. Please help us serve you better by keeping your scheduled appointments. ***We reserve the right to terminate our relationship as a result of repeated missed appointments.***

Returned Checks

There is a **$30.00** service charge for returned checks. In the event we receive more than one check returned for any reason you will be required to pay with cash or credit card.

I have read the above policies, consents and authorizations. I have been allowed to ask questions and my questions have been answered to my satisfaction. I understand and agree to all components of this document.

_____ _____

Signature of Patient or Responsible Party Date

_____

Relationship of Responsible Party (if applicable)

_____ _____

Witness Signature Date