Northwest Family Physicians, P. A.

PATIENT INFORMATION SHEET

NAME_____SOCIAL SECURITY # _____
LAST FIRST MI

ADDDRESS_____HOME PHONE_____

CITY_____STATE_____ZIP _____MOBILE PHONE_____

DOB_____SEX_____RACE_____MARITAL STATUS_____E-MAIL_____

EMPLOYMENT STATUS: (CIRCLE ONE) FULL TIME / PART TIME / NOT EMPLOYED / RETIRED

EMPLOYER NAME_____WORK #_____EXT_____

STUDENT: (CIRCLE ONE) FULL TIME / PART TIME / NONE

RESPONSIBLE PARTY (IF DIFFERENT FROM ABOVE) _____

ADDRESS_____**CITY**_____**STATE**____**ZIP**_____

HOME PHONE_____**MOBILE PHONE**_____**DOB**_____

SOCIAL SECURITY #_____**EMPLOYER NAME**_____

EMPLOYER PHONE #_____**EXT**_____

EMERGENCY CONTACT NAME_____RELATIONSHIP_____

DAY TIME PHONE # FOR EMERGENCY CONTACT_____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME_____**PHONE #**_____

CLAIM ADDRESS_____**CITY**_____**STATE**____**ZIP**_____

POLICY #_____**GROUP NAME**_____**GROUP #**_____

EFFECTIVE DATE_____**MOBILE PHONE**_____

POLICY HOLDERS NAME_____**SS#**_____

DOB_____**EMPLOYER NAME**_____**WORK #** _____

SECONDARY INSURANCE NAME_____**PHONE #**_____

CLAIM ADDRESS_____**CITY**_____**STATE**____**ZIP**_____

POLICY #_____**GROUP NAME**_____**GROUP #**_____

EFFECTIVE DATE_____**MOBILE PHONE**_____

POLICY HOLDERS NAME_____**SS#** _____

DOB_____**EMPLOYER NAME**_____**WORK #**_____

Northwest Family Physicians

Patient Consent and Authorization for Treatment

Patient Name: _____

Account Number: _____

Consent for Routine Treatment: I hereby consent to the rendering of medical care, which may include routine diagnostic procedures and such treatment as my physicians(s) or other at Northwest Family Physicians, P.A. consider to be necessary, I understand that:

A. It is the policy of Northwest Family Physicians, P. A. that, absent emergency or extraordinary circumstances, no substantial procedures are to be performed upon me unless and until I have been provided sufficient information to have. And understanding of the procedures or treatments involved and of the usual and most frequent risks and hazards inherent in the proposed procedures or treatments as well as an opportunity to discuss them with my physicians(s) or other health care professional(s) to my satisfaction: and
B. I have the right to consent, or to refuse consent, to any proposed procedure or therapeutic course.

Authorization for Release of Medical Information: Northwest Family Physicians, P. A. and/or my physician(s) are authorized to furnish any medical information relating to my treatment to my insurance company, health maintenance organization, preferred provider organization, alternative delivery system, governmental or charitable agencies and their agents, my employer, and professional review organizations with whom I may have coverage or who may be assisting in payment or evaluation of my medical care for the purpose of collecting payment therefrom. I acknowledge and agree that Northwest Family Physicians and/or my physician may during the course of my treatment grant access to students or faculty members in health care education programs to my medical records, observe or participate in my treatment, or utilize data obtained from my medical records as authorized by Northwest Family Physicians. I also authorize Northwest Family Physicians and/or my physician(s) to release any medical information to any licensed physician or medical facility to which I may be referred or transferred for further medical care. I understand that this authorization will not expire, but I may revoke this authorization, in writing and witnessed, at any time, except to the extent that action has already been taken in reliance on this authorization prior to its revocation.

Authorization to Release Medicare and Medicaid Information: I certify that the information provided by me in applying for payment under Titles V, XVIII and/or XIX of the Social Security Act is correct. I understand that health care services paid for under Medicare and Medicaid are subject to review by professional review organizations, which may recommend denial of payment if my medical condition does not warrant continued care. I hereby authorize those agencies responsible for determining eligibility under these programs to provide to Northwest Family Physicians and/or my physician(s) any information relating to the determination of my eligibility. I authorize Northwest Family Physicians to submit a claim to Medicare for payment. I request that payment of any bills for services furnished under the Medicare program be made to either me or Northwest Family Physicians as the individual claim form and Northwest Family Physicians may direct.

Advance Billing Notice/Waiver of Liability: Your physician, after history and physical examination, may recommend or advise certain tests and/or studies with Medicare, Medicaid or other third party payor may determine to be medically unnecessary, (for Medicare as defined under Section 1862 (a) 1 of the Social Security Act). If your physician or other health care professional(s) of Northwest Family Physicians have reason to believe

that Medicare, Medicaid or other third party payer may deny coverage, you will be so informed and requested to sign an Advanced Billing Notice or Waiver of Liability acknowledging you have been informed of such information and are agreeing to pay Northwest Family Physicians for these services, if Medicare, Medicaid or other third party payer deny benefit payment.(The above is a required notice of Medicare)

Your physician will only recommend and/or advise studies and/or tests, which he/she deems to be in your best interest.

Medicare Lifetime Beneficiary Authorization (Applies to Medicare Patients ONLY): I hereby request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by or in Northwest Family Physicians including physician services. I authorize any holder of medical or other information about me to release the Health Care Financing Administration (HICFA) and its agents any information needed to determine these benefits or benefits for related services.

Authorization to File Insurance Automatically: I hereby request and authorize Northwest Family Physicians to file claims automatically after services have been rendered me. Individual requests will not be made. I will advise in writing to Northwest Family Physicians any alteration to this request and authority.

Payment: I agree to pay all charges for medical care rendered by Northwest Family Physicians and it physician(s) to me. I guarantee the full and complete payment of all charges for medical care rendered by Northwest Family Physicians and its physicians. This is a guarantee of payment and not merely of collection, and I agree to be directly responsible for the payment of all charges. If I fail to pay any such charges due to Northwest Family Physicians and it becomes necessary for Northwest Family Physicians all costs of collection thereof, including reasonable attorney's fees incurred in connection therewith. I further agree that this authorization provides consent for Northwest Family Physicians to release and obtain credit information from the are Credit Bureau and Collection Agency.

Assignment of Insurance benefits (Not including Medicare): I hereby authorize payment directly to Northwest Family Physicians of medical or surgical benefits otherwise payable to me including major medical insurance (but not including Medicare). I understand that I am financially responsible to Northwest Family Physicians for its services in connection with treatment rendered during encounters , any such excess amount may first be applied to payment of any other treatment rendered and the balance, if any remains, shall be paid to me.

NORTHWEST FAMILY PHYSICIANS, P.A. PATIENT BILL OF RIGHTS I acknowledge that I have received a copy of the Northwest Family Physicians, P.A. Patient Bill of Rights.

PERSONAL PROPERTY: Northwest Family Physicians, P.A. is not responsible for personal property, worn or carried onto the property. Every precaution will be taken to assure no loss; however, patients are urged not to wear jewelry which may need to be removed for examination, diagnostic testing, or treatment.

If you are unable to cancel your appointment 24 hours in advance, you may be subject to a $50.00 NO SHOW FEE.

I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE PROVISIONS PERTAINING TO MY RELATIONSHIP WITH NORTHWEST FAMILY PHYSICIANS, P.A.

_____ _____

Date **Patient or Parent (If Minor)**

NORTHWEST FAMILY PHYSICIANS

FINANCIAL POLICY

OUR OFFICE FINANCIAL POLICY

We are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policy as an essential element of your care and treatment. If you have any questions, please feel free to discuss them with our staff at any time.

Unless other arrangements have been made in advance by either you or your health insurance carrier, payment is due at time of service. For your convenience, we accept Visa and MasterCard.

YOUR INSURANCE

We have agreements with many insurers. We will bill those plans with whom we have an agreement and will collect any co-payments at the time of service. In the event your health plan determines a service to be "not covered," you will be responsible for the charge determined by your insurance. In that event, we will bill you and payment is due upon receipt of the statement.

If you have insurance coverage with a plan that we do not have an agreement with, we will prepare and send the claim for you as a courtesy. Charges for your care and treatment are due at the time of service unless other arrangements are made by you in advance.

We will also bill your health plan for all services that we provide in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

MINOR PATIENTS

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.

I have read and understand the financial policy of the practice and I agree to be bound by its terms.

_____ _____

Signature of Patient or Responsible Party Date

_____

Please Print the Name of the Patient

ACKNOWLEDGEMENT OF RECIEPT OF PRIVACY PRACTICES

Northwest Family physicians reserve the right to modify the privacy practices outlined the notice.

SIGNATURE

A copy of the Notice of Privacy Practices has been made available to me. Also, at anytime I may request a copy for my personal records.

_____

NAME OF PATIENT (PRINT OR TYPE)

_____

SIGNATURE OF PATIENT

_____

DATE

_____

SIGNATURE OF PATIENT REPRESENTATIVE
(REQUIRED IF THE PATIENT IS A MINOR OR UNABLE TO SIGN THIS FORM)

_____

RELATIONSHIP OF PATIENT REPRESENTATIVE TO PATIENT

NORTHWEST FAMILY PHYSICIANS
Medical History

Name_____Referring or Previous Physician_____

Age____ Occupation_____Employer_____

Married, Single, Partnered (circle one) Children Y N Names_____

Significant Illnesses and Hospitalizations, past or present (High Blood Pressure, Diabetes, Heart Disease, Ulcers, STD's etc.)

_____
_____
_____
_____

Operations (any and all with dates)

_____
_____
_____

Habits
Tobacco_____ Alcohol_____ Exercise_____ Special Diet_____

Family History (check)

____Heart Problems Who? _____

____Colon Cancer Who? _____

____Prostate Cancer Who? _____

____Breast Cancer Who? _____

____Other Cancer Who? _____

____High Blood Pressure Who? _____

____Diabetes Who? _____

____Thyroid Disease Who? _____

When was your last: Complete Physical _____ Tetanus Shot _____

Flexible Sigmoidoscopy _____ Mammogram_____ Pap Smear _____

Northwest Family Physicians
7920 Moores Chapel Road
Charlotte, NC 28214
Phone (704) 926-7800 Fax (704) 926-7806
Authorization for Release of Medical Information

Name: _____

Birthdate (Mo/Day/YR): _____

Social Security #: _____

Street Address: _____

City/State/Zip Code: _____

Home Number: _____ **Cell Number:** _____

At the Request of the individual, I _____, **do hereby authorize the release of:**

__ Discharge Summary	__Pathology Reports	__Emergency Reports	Date of Service Range
__History & Physical	__Laboratory	__Progress Notes	From: ___/___/____
__Radiology	__Operative	__EKG/EEG/Cardiology	To: ____/____/_____

__Other: _____ All Records: _____

__I Do __I Do Not Authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, psychiatric care and/or psychological assessment and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO :	INFORMATION RELEASE FROM:
NAME OF COMPANY/AGENCY/PERSON:	NAME OF COMPANY/AGENCY/PERSON:
STREET ADDRESS/CITY/STATE/ZIP CODE:	STREET ADDRESS/CITY/STATE/ZIP CODE
PHONE:	PHONE:
FAX:	FAX:

Purpose of Disclosure: _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand I can cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosures by the person/ class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign this authorization.

_____ _____

Signature of Individual or Guardian or Representative of Estate Date