Patient Medical Record

Manager, Manager

23 mo F, DOB: Jan 1, 2021
Account Number: 987986

, NC

Patient Medical Record	Page(s)
Patient Documents	2 to 10
Total Pages	**10**

Note: There may be certain notes which are not made available as per your physician's discretion, please contact your physician's office to obtain those.

Northwest Family Physicians, P. A.

PATIENT INFORMATION SHEET

NAME_____ SOCIAL SECURITY # _____
LAST FIRST MI

ADDRESS_____ 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 #_____

ACKNOWLEDGEMENT OF RECIEPT OF PRIVACY PRACTICES

Northwest Family Physicians, P.A. reserves the right to modify the Privacy Practices outlined in the notice.

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.

ACKNOWLEDGEMENT OF RECIEPT SIGNATURE

_____
Name of Patient (Print)

_____
Signature of Patient

_____
Signature of Patient Representative
(Required if the patient is a minor or unable to sign this form)

_____
Relationship of Patient Representative to Patient

A copy of the Notice of Privacy Practices is available at the front desk if you wish to view or have a copy.

NORTHWEST FAMILY PHYSICIANS

PATIENT CONSENT AND AUTHORIZATION FOR TREATMENT

Patient Name: _____ **D.O.B.** _____

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. (NWFP)** consider to be necessary. I understand that:

A. It is the policy of **NWFP, 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 procedure(s) 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: **NWFP, 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 many 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 **NWFP** and/or my physician may, during the course of my treatment, grant access to students or faulty 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 **NWFP.** I also authorize **NWFP** 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. I authorize **NWFP** to submit 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 **NWFP** as the individual claim form and **NWFP** may direct.

Advance Billing Notice/Waiver of Liability: your physician, after history and physical examination, may recommend of advice certain tests and/or studies with Medicare, Medicaid, or another third-party

Patient Name:_____D.O.B._____

payor my determine to be medically unnecessary, (for Medicare as defined under Section 1862 (a) 1 of Social Security Act). If your physician or other health care professional(s) of **NWFP** 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 (ABN) or Waiver of Liability acknowledging you have been informed of such information and are agreeing to pay NWFP 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 e/she deems to be in your best interest.

Medicare Lifetime Beneficiary Authorization (Applies to Medicare Patient ONLY): I hereby request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished by me or in NWFP 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 **NWFP** to file claims automatically after services have been rendered me. Individual requests will not be made. I will advise in writing to **NWFP** any alteration to this request and authority.

Payment: I agree to pay all charges for medical care rendered by **NWFP** and its physician(s) to me. I guarantee the full and complete payment of all charges for medical care rendered by **NWFP** 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 owed to NWFP, and it becomes necessary for **NWFP** to pursue collection, I will be responsible for all cots of collection thereof, including reasonable attorney's fees incurred in connection therewith. I further agree that this authorization provides consent for **NWFP** to release and obtain credit information from the area Credit Bureau and Collection Agency.

Assignment of Insurance Benefits (not including Medicare): I hereby authorize payment directly to **NWFP** 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 **NWFP** 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 **NWFP, P.A.** Patient Bill of Rights.

Personal Property: NWFP, 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.

Patient Name:_____D.O.B._____

IF YOU DO NOT CANCEL YOUR APPOINTMENT IN ADVANCE, YOU ARE SUBJECT TO A $70.00 NO SHOW FEE. IF YOU HAVE 3 NO SHOWS WITHIN 1 YEAR, YOU ARE SUBJECT TO DISMISSAL.

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)

HEALTH HISTORY QUESTIONNAIRE **NORTHWEST FAMILY PHYSICIANS**

Please complete this entire questionnaire. It will provide your care team with important information about your health. All answers are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.)*:_____ **Male Female DOB**_____

Today's Date_____Marital status: Single Partnered Married Separated Divorced Widowed

Number of Children:_____ How many live with you?_____ Occupation is/was:_____

Previous doctor:_____ Date of last physical exam:_____

PERSONAL HEALTH HISTORY *(circle if applies)*:

Childhood Illness: Measles Mumps Rubella Chickenpox Rheumatic Fever Polio None

Immunizations and dates: Tetanus_____Pneumonia_____Hepatitis A_____Hepatitis B _____ Chickenpox_____Influenza_____MMR *Measles, Mumps, Rubella*_____

Meningoccoccal_____Zostavax *shingles*_____ COVID_____

Other immunizations_____

Test/Screenings and dates: Eye Exam_____Colonoscopy_____Dexa Scan_____

Surgeries/Hospitalizations: **I have never been hospitalized** ☐

Year_____ Reason_____ Hospital_____

Year_____ Reason_____ Hospital_____

Year_____ Reason_____ Hospital_____

YOUR Medical History *(circle if applies)*:

Alcohol Abuse	Growth/Development Disorder	Migraines
Anemia	Hearing Impairment	Osteoporosis
Anesthetic Complication	Heart Attack	Prostate Cancer
Anxiety Disorder	Heart Disease	Rectal Cancer
Arthritis	Heart Pain/Angina	Reflux/GERD
Asthma	Hepatitis A	Seizures/Convulsions
Autoimmune Problems	Hepatitis B	Severe Allergy
Birth Defects	Hepatitis C	Sexually Transmitted Disease

Name (Last, First, M.I.):_____ **DOB**_____

Bladder Problems	High Blood Pressure	Skin Cancer
Bleeding Disease	High Cholesterol	Stroke/CVA of the Brain
Blood Clots	HIV	Suicide Attempt
Blood Transfusion(s)	Hives	Thyroid Problems
Bowel Disease	Kidney Disease	Ulcer
Breast Cancer	Liver Cancer	Visual Impairment
Cervical Cancer	Liver Disease	Other disease, cancer
Colon Cancer	Lung Cancer	NONE of the Above
Depression	Lung/Respiratory Disease	
Diabetes	Mental Illness	

List your prescribed drugs, over-the-counter drugs, such as vitamins and inhalers, and how you are taking them (*list additional drugs on back of questionnaire)*:

_____ _____ _____

_____ _____ _____

I take NO medications

Allergies *(list additional allergies on back of questionnaire)*:

_____ _____ _____

I have NO KNOWN DRUG ALLERGY

YOUR Family Medical History (*ONLY include parents, grandparents, siblings, and children) circle all that apply*:

Family History Unknown	Colon Cancer	Migraines
Alcohol Abuse	Depression	Osteoporosis
Anemia	Diabetes	Other Cancer
Anesthetic Complication	Heart Disease	Rectal Cancer
Arthritis	High Blood Pressure	Seizures/Convulsions
Asthma	High Cholesterol	Severe Allergy
Bladder Problems	Kidney Disease	Stroke/CVA of the Brain
Bleeding Disease	Leukemia	Thyroid Problems
Breast Cancer	Lung/Respiratory Disease	NONE of the above

_____Mother, Grandmother, or Sister developed heart disease BEFORE the age of 65

_____Father, Grandfather, or Brother developed heart disease before the age of 55

_____ I am adopted and do not know biological family history

NORTHWEST FAMILY PHYSICIANS

FINANCIAL POLICY

OUR OFFICE FINANCIAL POLICY

We provide 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 may 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 have been made in advance.

NO SHOW POLICY

IF YOU NO SHOW, YOU ARE SUBJECT TO A $70.00 NO SHOW FEE. IF YOU HAVE 3 NO SHOWS WITHIN 1 CALENDAR YEAR, YOU CAN BE DISMISSED FROM THE 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

Updated: 10/2022

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**