Northwest Family Physicians

Patient Information Sheet

Name: ____
First M Last

Preferred/Nickname: ______________________________

Address: ____

City: ________________ State: ____________ Zip: ____________

DOB: ________________ Sex: ________ Marital Status: ____________

Home Phone: __________________ Cell Phone: __________________

Social Security #: ________________ Email: ____________________

Emergency Contact: ____

Phone #: ____________________ Relationship: __________________

If a patient is under the age of 18:

Responsible Party: ____

Phone #: ____________________ DOB: ________________________

Adress (If different from Above): ____________________________

Patient Consent and Authorization for Treatment

Patient Name: ____

Consent for Routine Treatment: I hereby consent to the rendering of medical care, which may include routine diagnostic procedures and such treatment as my physician(s) or other Northwest Family Physicians. P.A. consider it 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 physician(s) or other health care professional(s) to my satisfaction

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 purposes 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 record 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/Medicaid Information: I certify that the information provided by me in applying for payment under Titles V, XVIII and 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 Northwest Family Physicians and/or my physician(s) any information relating to the determination oof 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.

Advanced 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 payors that 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 payor may deny coverages, you will be so

informed and requested to sign an Advanced 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 payor 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 by me 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 (HCFA) and its agents any information needed to determine these benefits or benefits related to related services.

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

Payments: I agree to pay all charges for medical care rendered by Northwest Family Physicians and its physician(s) to me. I guarantee the full and complete payment of all charges for medical care rendered by Northwest Family 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 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 hrs in advance, you may be subject to a $70.00 no show fee.

I have read, understand, and agree to the above provisions pertaining to my relationship with Northwest Family Physicians, P.A.

Date: ______________________ Signature: ____

Acknowledgement of Receipt
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 any time I may request a copy for my personal records.

Acknowledgement of Receipt 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

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 cash, all major credit cards, apple pay. We **do not accept** Care Credit.

Your Insurance

We have agreements with many insurers. We will bill those plans with whom we have an agreement and 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 WIITHIN 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 and conditions.

__________________________________ ______________________________

Signature of Patient or Responsible Party Date

____

Please Print the Name of the Patient

Consent For Release of Protected Health Information To Family

I consent to disclosure of the following protected health information about me to the following family member(s) or person(s) involved in my care or payment of care:

____________________ Name

____________________ Name

____________________ Name

____________________ Name

____________________ Name

____________________ Name

Check All That Apply:

____ All my medical information

____ Information necessary to schedule appointments for me

____ Lab or test results

____ Information necessary to provide, call in or pick up prescriptions for me

____ Information necessary to help my family member(s) take care of me

____ Information necessary to allow my family member(s) to pick up or arrange for medical equipment to be provided

____ Information necessary to bill for or submit claims for care provided to me to government/private payors

My consent will remain in effect as long as I am a patient of Northwest Family Physicians unless and until I notify Northwest Family Physicians in writing or any changes.

____________________ Signature of Patient or Representative

____________________ Date

____________________ Print Name

____________________ Relationship of Representative to Patient

Medical History Form

Name: ______________________________ Date: ________________

Reason for Visit: ____

Personal Medical History: Have you ever had any of the following? (Check if Yes)

___ Anemia	___ Crohn's Disease	___ HIV / AIDS
___ Arthritis	___ Depression	___ Hypertension
___ Asthma	___ Diabetes	___ Kidney disease
___ Alzheimer's Disease	___ Emphysema	___ Myocardial Infarction
___ COPD	___ Endocrine Problems	___ Peptic Ulcer Disease
___ Clotting Disorder	___ GERD	___ Seizures
___ Congestive Heart Failure	___ Glaucoma	___ Stroke
___ Hepatitis	___ Ulcerative Colitis	___ Cancer

Personal Surgical History: List name and dates of any Surgeries

______________________________ Date: ______________

______________________________ Date: ______________

______________________________ Date: ______________

______________________________ Date: ______________

Medications:

____

____

____

____

Allergies:

____

____

NORTH CAROLINA AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Information: I give permission to release the health information of: **(One Patient Per Form)**

Patient Name: ______________________ Date of Birth: ______________________

Street Address: ______________________ City, State, Zip: ______________________

Telephone: ( ) ______________________ Email Address: ______________________

Release Information From:

____

(List applicable Facility(s) and/or Practice(s)

____

____

(Phone number) (Fax number)

Release Information To:

____

(Name of facility, person, company) (Relationship)

____

(Street Address or PO Box, City, State, Zip Code)

____

(Phone number) (Fax number)

PURPOSE OF RELEASE (check reason): ☐ Request of individual/personal rep ☐ Continued patient care ☐ Insurance ☐ Legal purpose including discussions & proceedings ☐Other

Fill in dates of treatment for records to be released:
Treatment dates: From ______________________ To ______________________

Facility (check all that may apply):
- ☐ Facility Summary – includes items in bold
- ☐ **Discharge Summary**
- ☐ **History and Physical**
- ☐ **Consultation reports**
- ☐ Assessment
- ☐ **Operative Reports**
- ☐ **Laboratory reports**
- ☐ **Radiology/X-Ray Reports**
- ☐ **Pathology reports**
- ☐ **Emergency Record**
- ☐ **Cardiac Reports/EKG**
- ☐ Other ____________

- ☐ Entire record
- ☐ Itemized Bill

Office/Clinic/Home Care (check all that may apply):
- ☐ Office/Clinical Summary – includes items in bold
- ☐ **Office/Home Visits**
- ☐ **Physical Exam**
- ☐ **Laboratory Reports**
- ☐ **Radiology Reports**
- ☐ Therapy Notes
- ☐ Immunization Records
- ☐ Other ____________

- ☐ Entire Record
- ☐ Itemized Bill

FORMAT:
- ☐ CD (charges may apply)
- ☐ Email Address noted above, where permitted
- ☐ Paper copy (charges may apply)
- ☐ Other ______________________

DELIVERY METHOD:
- ☐ Reg.US Mail ☐ Pick-up ☐ Fax, where permitted
- ☐ Overnight/Express Mail Service, where permitted
- ☐ Secure email
- ☐ Other: ______________________

PATIENT'S RIGHTS – I understand that:
- **I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice.**
- **This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases.**
- **Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections. Records protected by 42 CFR Part 2 may not be redisclosed without my additional consent**
- **Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in health plan, or eligibility for benefits.**
- **The individual or organization will not share or use my health information without my permission other than by ways listed in the Notice of Privacy Practices or as required by law.**
- **I have a right to a copy of this Authorization.**

This permission expires one year after the date of my signature unless another date or event is written here: ______________________

Signature: ______________________ **Print Name:** ______________________ **Date:** ____________

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form.
Note the relationship/authority if signature is not that of the patient (Written proof MAY be requested):
☐ **Healthcare Agent/POA** ☐ **Guardian** ☐ **Executor/Administrator/Attorney in Fact** ☐ **Spouse**
☐ **Parent** ☐ **Adult Child** ☐ **Affidavit Next of Kin** ☐ **Other:** ______________________

Note: If minor consented for their outpatient treatment for pregnancy, sexually transmitted disease or behavioral/mental health without parental consent, the minor must sign this authorization. When the patient is a minor being treated for substance abuse, the minor must sign this authorization, regardless of who consented for treatment.

Signature of Minor: ______________________ **Print Name:** ______________________ **Date:** ____________

Date of release: ______________________ via ☐Mail ☐Fax ☐Other ____________ ☐ID Verified ☐DL/Other ID ____________
Representative or Organization: ______________________ Date: ____________ # of Pages ____________