Patient Registration Information

Please PRINT and complete ALL sections below!

PATIENT'S PERSONAL INFORMATION

Marital Status: *(circle one)* Single Married Divorced Widowed **Birth Sex:** *(circle one)* Male Female

Name: ___________________________________ ____________________________________ __________
last name *first name* *middle initial*

DOB: ____ /____ /____ **Social Security #:** _____ - _____ - _____ **Primary Phone:** *(circle one)* Cell Work Home

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

Address: ____ **Apt. #** ______________

City: ____ **State:** ___________________________ **Zip:** ________________

***Email:** ____

Race: ____ **Ethnic Group:** ___________________________________

PATIENT'S INSURANCE INFORMATION *(Please present insurance cards to receptionist)*

PRIMARY Insurance: ____

Address: ____ **City:** _________________________

State: _____________________________________ **Zip:** ________________________

Name of Insured: ____ **Date of Birth:** ______ / ______ / ______

Relationship to Insured: *(circle one)* Self Spouse Child Other

Policy #: _________________________________ **Group #:** _________________________________**Copay $:** _________

SECONDARY Insurance: ____

Address: ____ **City:** _________________________

State: _____________________________________ **Zip:** ________________________

Name of Insured: ____ **Date of Birth:** ______ / ______ / ______

Relationship to Insured: *(circle one)* Self Spouse Child Other

Policy #: _________________________________ **Group #:** _________________________________**Copay $:** _________

PATIENT'S/ RESPONSIBLE PARTY INFORMATION

Relationship to Patient: *(circle one)* Self Spouse Child Other

Name: ___________________________________ ____________________________________ __________
last name *first name* *middle initial*

DOB: ____ /____ /____ **Social Security #:** _____ - _____ - _____ **Primary Phone:** *(circle one)* Cell Work Home

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

Address: ____ **Apt. #** ______________

City: ____ **State:** ___________________________ **Zip:** ________________

PHARMACY INFORMATION

Name: ____**Address:** ____________________________________

City: _________________________**State:** _____________________________________ **Zip:** ________________________

Phone: (_______) - _______ - _______ **Fax:** (_______) - _______ - _______

EMERGENCY CONTACT

Name: ____**Relationship:** ______________________________________

Address: ____**City:** ____________________ **State:** ______ **Zip:** _________

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

Assignment of Benefits / Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to **North State Medical Group, PA,** and any assisting physicians for services rendered. I understand that I am financially responsible for all charged whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and responsible attorney's feed. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as original.

Date: ____ **Signature:** ____

WELCOME TO NORTH STATE MEDICAL GROUP

As part of the intake process to establish you as a new patient, or to update our files for those who are established patients at our facility, the information on the reverse sides needs to be completed in full. Please take the time to complete all the information. For those of you who are already established patients. Please bear with us as this is required of us for each new calendar year.

In an effort to keep our fees down through controlling administrative costs, we have implemented the following payments policies:

- All payments and co-payments are to be made at the time of your visit, unless prior arrangements have been made. We participate in most major insurance networks and we will bill the insurance company if you are a participant in one of the participating programs. Ig you are not covered by one of these plane, you will be required to pay at the time of service, unless special financial arrangements have been made with our billing department prior to service. Upon full payment for this service, you will be given an insurance ready receipt in which you may file with your insurance company for reimbursement.

Accepted methods of payment by this office include:
***Cash, Money Order, Cashier's Check**
***Local-personal checks with proper picture ID**
***Visa and MasterCard with proper picture ID**

<u>*There will be a $25.00 service fee for all returned checks!</u>

- INSURANCE: While we try to help in any way possible, please remember that insurance is a contract between you and your insurance provider. YOU, therefore, are ultimately responsible for your medical bills. Any charges billed to insurance for services performed at our facility which remain outstanding for more than 60 days, will become the responsibility of that patient or appropriate account Guarantor (in the case of a dependent child or adult). At this time, if you feel these charges have been unjustly denied by your insurance carrier, it is YOUR responsibilities to contact your insurance carrier to appeal their decision.

<u>If you have any questions concerning the payment policy, please ask PRIOR to being seen by the physician or nurse.</u>

I, undersigned, have read, understand, and agree to abide by the above policies of North State Medical Group, PA.

Signature: ____ **Date:** _________________________

NORTH STATE MEDICAL GROUP, P.A.

Patient: ____

Guarantor: ____

Account #: ______________________________________

I have reviewed the billing information on the above account and hereby certify that this is the correct information for processing my insurance.

If this information is not correct I understand that I will be responsible for any balance due if the claim is denied. I will be responsible if I do not produce the correct information in a timely fashion needed to process my claim for payment.

Patient / Guarantor Signature: ____

Date: _______________________________________

Witness Signature: ____

Date: _______________________________________

NOTICE OF PRIVACY PRACTICES

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.

USE AND DISCLOSURE TREATMENT

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations: Your health information may be used as necessary to support the day-to-day activities and management of North State Medical Group, P.A. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement: Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

ADDITIONAL USES OF INFORMATION

Appointment reminders: Your health information will be used by our staff to send you appointment reminders.

Information about treatments: Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you.

INDIVIDUAL RIGHTS

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

North State Medical Group, PA Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

RIGHT TO REVISE PRIVACY PRACTICES

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

REQUESTS TO INSPECT PROTECTED HEALTH INFORMATION

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our office.

COMPLAINTS

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Officer
North State Medical Group
2266 North Highway 16
Denver, NC 28037

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

CONTACT PERSON

The name and address of the person you can contact for further information concerning our privacy practices is:
Privacy Officer
North State Medical Group
2266 North Highway 16
Denver, NC 28037

EFFECTIVE DATE

This Notice is effective on and after March 10, 2003

NORTH STATE MEDICAL GROUP, P.A.

Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of Your Protected Health Information
Your protected health information will be used by North State Medical Group, PA or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices
You should review the Notice of Privacy Practices we have given you for a more complete description of how your protected health information may be used or disclosed. We encourage you to review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information
You may request a restriction on the use or disclosure of your protected health information.

North State Medical Group, PA may or may not agree to restrict the use or disclosure of your protected health information.

If North State Medical Group, PA agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected health information in violation of an agreed upon restriction will be violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected,

Reservation of Right to Change Privacy Practices
North State Medical Group, PA reserves the right to modify the privacy practices outlined in the notice.

Signature
My signature below signifies that I have received a copy of the Notice of Privacy Practices and that I have reviewed this consent form and give my permission to North State Medical Group, PA to use and disclosure my health information in accordance with the privacy practices.

____

Name of patient

_____________________________ _______________

Signature of patient *Date*

(Optional) I designate ____ as my patient representative

(Print name of patient representative)

___________________________ ___________________________________

Relationship to Patient *Signature of patient representative, if available*