❑ FHC at Biltmore ❑ FHC at Cane Creek ❑ FHC at Newbridge ❑ FHC at Enka/Candler
❑ Center for Psychiatry ❑ Deerfield ❑ Givens

FAMILY HEALTH CENTERS PATIENT REGISTRATION FORM

Please complete the following information using BLACK ink. ****This information is confidential****

Name ______________________________ SS #________________

Address ______________________ City____________State_____ Zip________

Home county _______________E-mail address ______________________

Home phone ____________________ Work/cell phone __________________

By providing a phone number, mobile phone number or email address, I authorize MAHEC to contact me or my guardian/legal representative to remind me of appointments, to obtain feedback on my experience at this office, and to provide general health reminders and other information regarding my healthcare.

Birth Date ______________ Gender: ❑ Male ❑ Female

Marital Status: ❑ Single ❑ In a relationship ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

In case of emergency, contact:
Name______________________ Relationship ___________ Phone #__________

IF PATIENT IS CHILD (18 & UNDER): Responsible Party Name:______________________

Relationship to patient ________________ Phone #______________________

Please list: Special hearing needs: ______________ Special vision needs: ______________

What is your race / ethnicity? (check all that apply):

❑ American Indian or Alaska Native ❑ Asian ❑ Native Hawaiian ❑ Other Pacific Islander

❑ Black or African American ❑ Hispanic or Latino ❑ White ❑ Other (please describe):___________

Preferred Language: ❑ English ❑ Spanish ❑ American Sign Language ❑ Russian ❑ Other___________

INSURANCE INFORMATION

Insurance company ______________________________________

Policy holder's name ________________________ Policy holder's date of birth __________

Policy holder's relationship to patient: ______________________________

Policy holder's address: ______________________________________

____

Policy holder is ❑ male ❑ female Policy ID# ____________________________

ASSIGNMENT OF BENEFITS AND FINANCIAL POLICY

I hereby authorize payment of all insurance, Medicaid and/or Medicare benefits directly to MAHEC Family Health Center and I authorize them to file insurance on my behalf. I also authorize them to release medical/and or account information to my insurance, Medicaid and/or Medicare carrier as required to satisfy claims. I agree to notify them should my coverage change.

I understand MAHEC Family Health Center:

- Expects payment on the date of service (if insured, co pays and deductibles are expected on the date of service).
- Accepts cash, checks, debit cards or major credit cards.
- Expects Medicaid, Medicare and all insurance will be filed for me. However, it is my responsibility to know the details of my insurance coverage and provide MAHEC with current and accurate information.
- Will work with me to establish payment plans.
- Provides services and treatment, which are medically appropriate. However, some of these may not be covered by my insurance plan and these will be my responsibility to pay.
- Expects my insurance company to pay within 90 days from the date of service and will bill me directly if the insurance does not pay.
- Expects the parent or guardian to pay for all services rendered to their dependents.
- Expects me to keep appointments and to call at least 24 hours prior, if I need to cancel. I understand that failure to do this may result in being discharged from the practice

.

I have read and understand the above: ____________________________________ Date___________________

Patient or Guardian Signature

Note: Failure to sign does not relieve you of the above expectations

CONSENT FOR TREATMENT

I voluntarily consent to routine services, medical treatment(s), diagnostic radiology procedure(s), diagnostic lab(s), behavioral health services and services offered by lay health workers (e.g. doula, community health worker, peer support specialist) as deemed necessary by the healthcare providers treating me. I voluntarily consent to allow MAHEC to seek emergency medical care from a physician or hospital, if needed. I understand that diagnostic procedures may include but are not limited to lab tests on blood, urine, and tissue, including drug screenings. I understand that diagnostic radiology procedures include but are not limited to x-ray, ultrasound and/or mammography. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may cause injury or even death. I understand I have the right to ask questions about my treatment and/or procedures and the right to refuse any treatment or procedure. I agree to notify my provider of my concerns.

Patient, Parent or Guardian Signature ___________________________________ Date___________________

VERBAL COMMUNICATION CONSENT

MAHEC is authorized to discuss medical and financial information concerning the care and services provided to me with the following individuals:

____ ____

____ ____

Today's Date: _____________________

NOTICE OF PRIVACY ACKNOWLEDGMENT

I have been given the opportunity to read MAHEC's Notice of Privacy Practices, and my questions concerning the Notice have been answered. I understand if I choose not to sign this acknowledgment MAHEC will continue to provide services to me and will use and disclose my Protected Health Information (PHI) for treatment, payment, and healthcare operations when necessary.

Patient, parent or guardian signature ___________________________________ Date__________________

FOR OFFICE USE ONLY: Primary Care Provider ____

Copy of insurance card obtained? ❑ yes ❑ no

Family Health Centers
New Patient Intake Form

PATIENT NAME ______________________________ **DATE OF VISIT** ______________

FORM COMPLETED BY ______________________________ **DATE OF BIRTH** ______________

Have you received medical care from another family physician, pediatrician, internist or specialist at another practice in the last 5 years? ❑ Yes ❑ No

If yes, please give name and city. ______________________________

ALLERGIES OR BAD REACTIONS TO MEDICINES
Please list the medicine that bothers you and the bad reaction it causes, or check that you have no allergies ❑ No allergies

Name of Medicine	Reaction caused

MEDICATIONS
Please list ALL medications you are currently take (including birth control pills, vitamins and herbs), even if you do not take them every day, and even if they are over the counter.

Name of medication	Dose size (usually mg)/#tabs	How often taken

PHARMACY

Local: ______________________________

Mail Order: ______________________________

THE FOLLOWING PEOPLE CURRENTLY MAKE UP MY HOUSEHOLD

Name	Age	Relation to me

Patient Name____ Date of Birth ______________________

SOCIAL HISTORY

Single Married Divorced Widowed *(circle one)*

Not married, living together since ____________________

Other ____

Occupation ____

Currently employed at ____ since ____________________

Job title/responsibilities ____

Homemaker since ____ Retired since ____________________

Former job ____ Disabled due to ____________________

Highest education completed ____

What is your gender identity ____

ARE ANY OF THE FOLLOWING PROBLEMS PRESENT IN THE HOUSEHOLD

Alcohol or other substance abuse ❑ Yes ❑ No

Marital/Relationship problems ❑ Yes ❑ No

Financial problems ❑ Yes ❑ No

Other household problems - Explain ____

Recent or significant loss of a family member ❑ Yes ❑ No

Caregiver problems or issues ❑ Yes ❑ No

FOR WOMEN ONLY

How many pregnancies ______

How many live births ______

How many miscarriages or abortions ______

How many C-sections ______

Ever had abnormal pap smears ❑ Yes ❑ No

When was your last pap smear ______

Was it normal ❑ Yes ❑ No

When was your last mammogram ______

Was it normal ❑ Yes ❑ No

Menopause (change of life) since _______

Are you currently taking a multi vitamin with folic acid daily ❑ Yes ❑ No

REPRODUCTIVE HEALTH (MEN AND WOMEN)

What is your sexual orientation ____

Would you or your partner like to become pregnant in the next year ❑ Yes ❑ No ❑ Maybe ❑ Unsure

Are you or your partner currently using any method to prevent pregnancy ❑ Yes ❑ No If so, what ____________________

Do you or your partner use condoms ❑ Yes ❑ No

IMPORTANT INFORMATION ABOUT INSURANCE COVERAGE FOR WELLNESS VISITS

Patient Name: ____________________

Date of Birth: ____________________

Appt. Type: ____________________

Provider: ____________________

Many insurance companies now provide 100% coverage with no copays for wellness / preventive health visits and screenings. Examples of wellness visits are annual exams, yearly physicals, well woman exams, well child checks, and Medicare annual wellness visits.

We would like to make sure you have access to all of the preventive health services we offer here at MAHEC. However, it is important to note that **if other services are provided during your wellness visit you may be responsible for a copay and other charges for that portion of your visit.**

Examples of care not covered by most insurance companies as part of a wellness visit include lab testing, sick visits, injuries, follow up and prescription refills for chronic conditions such as diabetes, hypertension, or follow up and treatment for abnormal lab results, such as a pap test.

Because there are many differences in coverage among insurance plans, it is important that you confirm your insurance coverage and benefits before your visit.

In an effort to prevent unexpected expenses, please let us know what type of visit you are requesting today by checking an option below. This will help your provider understand your concerns and discuss a plan to meet all of your needs. If all of your needs cannot be met within the time allotted on the schedule for today, we will schedule time for a follow up visit.

____ I would like my wellness / preventive health visit **only** today.

____ I would like my wellness visit **and** I want to discuss the following problems, prescriptions, conditions or concerns with my provider today, **and I understand there will be additional copay and/or charges for the problem care I receive:** ____

____ I would like a problem focused visit today and understand **there will be a copay and/or charges for this care.** The reason for my visit today is: ____

Patient Signature: ______________________________ Date: ____________________

If you have any questions, just let us know.

Thank you!

INCOMING TO MAHEC

MAHEC Family Health Centers
Centralized Medical Records Department
123 Hendersonville Road, Asheville, NC 28803 | Business Office Phone: (828) 771-3408 | Fax: (828) 407-2637

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

Patient Name: ____**Date of Birth:**___________________

I authorize the use or disclosure of the above named individual's health information as described below.

The information is to be disclosed by:	**And is to be provided to:**
NAME OF FACILITY:	**MAHEC Family Health Centers Centralized Medical Records Dept.**
ADDRESS:	**123 Hendersonville Road**
CITY/STATE: PHONE #: FAX #:	**Asheville, NC 28803**

The purpose or need for this disclosure is:

I understand that the information released may include sensitive information related to behavior and/or mental health, drugs and alcohol (including records of a program that provides alcohol or drug abuse diagnosis, treatment, or referral, as defined by federal law at 42 CFR Part 2), rape, abuse (sexual, physical, elder, spousal, etc.) abortion, sexual diseases like HIV/AIDS and other communicable disease and genetic testing.

Information to be disclosed: *(check appropriate box(es))*

- ☐ Standard release (last 3 years of notes, lab/x-ray reports, med list, allergy list, immunization record, consult notes.)
- ☐ Only information related to *(specify)*: ____
- ☐ Only the period of events from: ______________________ to ______________________
- ☐ Entire medical record
- ☐ Exclusions __ AIDS/HIV test results, diagnosis, treatment, and related information
  - __ Drug screen results and information about drug and alcohol use and treatments
  - __ Mental health notes
  - __ Genetics testing

I understand that this authorization will expire 90 days from the date it is signed unless I have specified a different expiration date or expiration event as follows. ____

I understand that I may cancel this authorization at any time by notifying in writing the MAHEC Privacy Officer, 121 Hendersonville Road Asheville, NC 28803, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.

I understand that information used or disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state laws.

I understand that MAHEC will not condition treatment or eligibility for care on the provision of this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

By signing below, I acknowledge that I have read and understand this Authorization.

SIGNATURE OF PATIENT	DATE
SIGNATURE OF AUTHORIZED REPRESENTATIVE PATIENT, IF APPLICABLE ***(State relationship to Patient)***	DATE
WITNESS TO SIGNATURE, IF APPLICABLE	DATE

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.