Name _____ **Date of Birth** _____/_____/_____ **Date** _____

MAHEC

Brief Review of Systems

Thank you for telling us your main concern today. Please indicate if you have had any of the following symptoms in the last 2 weeks. This can help your provider address your concerns and may also identify concerns for a follow up visit.

General

- ❑ Fatigue
- ❑ Unintentional weight loss

Skin

- ❑ New skin growth
- ❑ Non healing sores
- ❑ Rash

Eye Ear Nose Throat

- ❑ Change in Vision
- ❑ Hearing loss
- ❑ Frequent stuffy nose
- ❑ Difficulty Swallowing

Lungs

- ❑ Cough
- ❑ Difficulty breathing
- ❑ Wheezing

Heart

- ❑ Chest pain or pressure
- ❑ Difficulty breathing lying down
- ❑ Difficulty breathing on exercise
- ❑ Swelling / edema
- ❑ Heart skips

1. What would you like to discuss today?

_____

2. What prescription refills do you need today?

_____

3. Have you had your flu shot in the last year ❑ yes ❑ no

Gastro Intestinal

- ❑ Abdominal pain
- ❑ Blood in bowel movement
- ❑ Constipation
- ❑ Diarrhea
- ❑ Heartburn
- ❑ Nausea
- ❑ Vomiting

Men's Health

- ❑ Difficulty with urination
- ❑ Problems with sex
- ❑ Up at night to urinate

Women's Health

- ❑ Bleeding after menopause
- ❑ Pain with urination
- ❑ Difficulty holding urine
- ❑ Problems with sex
- ❑ Trouble with periods

Musculoskeletal

- ❑ Backache
- ❑ Painful joints
- ❑ Muscle pain

Neurological

- ❑ Decreased memory
- ❑ Fainting / passing out
- ❑ Headaches
- ❑ Numbness
- ❑ Weakness

Mental Health

- ❑ Feeling nervous, anxious or on edge
- ❑ Change in sleep pattern

Over the past 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things:

- ❑ Not at all
- ❑ Several Days
- ❑ More than half the days
- ❑ Nearly every day

Feeling down, depressed or hopeless:

- ❑ Not at all
- ❑ Several Days
- ❑ More than half the days
- ❑ Nearly every day

❑ FHC at Biltmore ❑ FHC at Cane Creek ❑ FHC at Newbridge ❑ FHC at Enka/Candler

❑ Center for Psychiatry ❑ Deerfield ❑ Givens

MAHEC

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

Patient Name: _____
Date of Birth: _____
Appt. Type: _____
Provider: _____

IMPORTANT INFORMATION ABOUT INSURANCE COVERAGE FOR WELLNESS VISITS

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.