WELCOME TO OUR PRACTICE

We are happy you have chosen MAHEC Family Health Centers for your care!

We are a group practice offering care for the entire family where patients of all ages can establish their care. We are a primary care medical home, meaning our team of healthcare professionals work together to provide all of your healthcare needs. You, the patient, are the most important part of a patient-centered medical home. We strive to provide evidence-based care in a professional, supportive atmosphere. Our providers look forward to an on-going relationship with you and an exceptional patient experience at every appointment.

Our full-spectrum family healthcare services include

- Primary care for children, adults and older patients
- Family-centered obstetrics including lactation consultation for breastfeeding support
- Sports medicine
- Family therapy and individual counseling
- Free interpreter services
- Geriatric medicine
- Hep C/HIV treatment
- Positive parenting program (Triple P)
- Integrated clinical pharmacy support, laboratory services and X-Rays
- Medication for opioid use disorder and substance abuse recovery support
- No-scalpel vasectomies and other procedures
- Nutritional counseling with registered dietitians including pediatric healthy weight medical visits
- IDD clinical care
Welcome to MAHEC!

Thank you for choosing us for your healthcare. MAHEC has been a part of Asheville since 1974 and we proudly continue our tradition of award-winning care. Our providers and staff welcome the opportunity to care for your entire family at our Family Health Centers, Internal Medicine office, OB/GYN offices, Dental offices and Center for Psychiatry. We proudly serve all patients regardless of income or insurance status.

- MAHEC is expanding our financial assistance program to go above and beyond what we have offered before. In order to facilitate this change we are asking all existing and new patients to complete a new patient information packet.
- Our Patient Financial Advocates are available to guide you through signing up for assistance offered through our Sliding Scale Discount Program. Eligibility is based on family income and family size. Payment is expected at time of service for amounts you are responsible for. We can assist with payment options if you are unable to pay in full.

BEFORE YOUR VISIT

This welcome packet includes forms you need to read and complete before your visit.

It is VERY important that you fill out each form completely and give the entire packet to the front desk staff when you arrive for your appointment. Please arrive 15 minutes before you appointment to complete the check-in process.

Other documentation you need to bring with you:

- Insurance card and driver’s license (or other valid photo ID)
- Pertinent medical history or records
- Current List of medications or medication bottles
  - Drug name
  - Prescribed dosage(s)
  - How long you have been taking the drug(s)

MAHEC’s Patient Portal

We are pleased to provide all patients with an online tool that provides 24/7 access to your personal health record. With the portal, you can securely email your provider, see lab results, review your medical records and much more. We will use the email address you provide to give you access to the portal if you don’t currently have it. Just watch for an email with instructions that will come to you after your appointment.

Thank you for choosing us for your healthcare!

Mountain Area Health Education Center
www.mahec.net
Who may we speak with?

This form will allow MAHEC to discuss your medical and financial information about the care and services you have received with individuals of your choosing. This form does not allow the listed individuals to obtain copies of your medical or financial information. You may list up to three (3) individuals below OR choose not to list anyone. You can update this form at any time.

Person #1 that we can speak with

Name: ____________________________________________________________

Relationship: ____________________________ Phone #: ______________________

Person #2 that we can speak with

Name: ____________________________________________________________

Relationship: ____________________________ Phone #: ______________________

Person #3 that we can speak with

Name: ____________________________________________________________

Relationship: ____________________________ Phone #: ______________________

OR

☐ I do not wish to list anyone at this time.

__________________________________________  ________________________
Signature of patient, parent, or legal guardian    Date
MAHEC Patient Registration Form

Please complete the following information using black ink. THIS INFORMATION IS CONFIDENTIAL.

PATIENT INFORMATION

Name: ___________________________ Date of Birth: ___________________________
Mailing Address: ___________________________ Birth Sex: □ Male □ Female
City: ___________________________ State: _______ ZIP: _______ SS#: ___________________________
Home County: ___________________________ Email Address: ___________________________
Home Phone: ___________________________ Cell Phone: ___________________________ Work 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.

Special Hearing Needs: ___________________________
Special Vision Needs: ___________________________

Race (select one):
□ Asian Indian
□ Chinese
□ Filipino
□ Japanese
□ Korean
□ Vietnamese
□ Other Asian
□ Native Hawaiian
□ Other Pacific Islander
□ Guamanian/Chamorro
□ Samoan
□ Black/African American
□ American Indian/Alaska Native
□ White
□ More than one race

Gender Identity:
□ Male
□ Female
□ Transgender Male
□ Transgender Female
□ Other
□ Choose not to disclose

Sexual Orientation:
□ Lesbian or Gay
□ Heterosexual (or straight)
□ Bisexual
□ Something else
□ Don’t know
□ Choose not to disclose

Preferred Language:
□ English
□ Spanish
□ Russian
□ American Sign Language
□ Other: ___________________________

Marital Status:
□ Single
□ In a relationship
□ Partner
□ Married
□ Separated
□ Divorced
□ Widowed

Special Populations
□ Migratory □ Yes □ No
□ Seasonal □ Yes □ No
□ Homeless □ Yes □ No

Homeless Status (select one):
□ Not Homeless
□ Homeless Shelter
□ Transitional
□ Doubling Up
□ Street
□ Permanent Supportive Housing
□ Other
I hereby authorize payment of all insurance, Medicaid, and/or Medicare benefits directly to MAHEC 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 that MAHEC:

- 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.

Patient or Parent/Guardian Signature: ___________________________ Date: ___________________________

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 at any MAHEC facility. 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 or Parent/Guardian Name (please PRINT): ____________________________________________________________________________

Patient or Parent/Guardian Signature: ___________________________ 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) in accordance with MAHEC’s Notice of Privacy Practices.

Patient or Parent/Guardian Signature: ___________________________ Date: ______________

For Office Use Only

Primary Care Provider: ____________________________________________

Copy of insurance card obtained? ☐ Yes ☐ No
New Patient Intake Form

Patient Name: ________________________________ Date of Birth: ______________

Form Completed by: __________________________ Date of Today’s Visit: _____________

Have you received medical care from another physician in the last 5 years? ☐ Yes ☐ No If yes, please give name and location. Physician name: __________________________

Physician city and state: __________________________

What is the reason for your visit today? __________________________________________

ALLERGIES

Do you have any allergies or bad reactions to medicines, foods or latex? ☐ Yes ☐ No If yes, please list them below.

Medicine, food, latex or other substance: __________________________________________

Reaction caused: __________________________________________

MEDICATIONS

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

Name of medication, vitamin, herb or supplement: __________________________

Dosage (ex: how many mg or tablets you take): __________________________

How often you take it: __________________________

Are you taking a multivitamin with folic acid? ☐ Yes ☐ No

Local Pharmacy: __________________________

Mail Order: __________________________

MEDICAL HISTORY

Have you ever had any the following? Please check the boxes of all that apply to you.

☐ Alcohol abuse ☐ Cancer, other: __________________________

☐ Anemia ☐ COPD/Emphysema ☐ History of physical abuse ☐ Thyroid trouble

☐ Anxiety ☐ Depression ☐ History of sexual abuse ☐ Other:

☐ Arthritis ☐ Diabetes ☐ Irritable Bowel Syndrome

☐ Asthma ☐ Drug Abuse ☐ Kidney disease

☐ Attention Deficit Disorder ☐ GERD/Reflux ☐ Kidney stones

☐ Bipolar Disorder ☐ Heart attack, when: __________________________

☐ Bladder problems ☐ Heart failure

☐ Blood clots ☐ Hepatitis, choose: ☐ A ☐ B ☐ C

☐ Breast cancer, when: __________________________

☐ High blood pressure ☐ Skin cancer, when: __________________________

☐ Colorectal cancer, when: __________________________

☐ High cholesterol ☐ Stroke

July 2021
Patient Name: ___________________________  Date of Birth: __________________

SURGICAL HISTORY

What surgeries or procedures have you had? Please check the boxes of all that apply to you.

☐ Amputation, where: _______________  Year: ______  ☐ Hernia repair  ☐ Left  ☐ Right  Year: ______

☐ Appendix removed Year: ______  ☐ Knee surgery  ☐ Left  ☐ Right  Year: ______

☐ Artificial joints, where: _______________  Year: ______  ☐ Neck surgery  ☐ Left  ☐ Right  Year: ______

☐ Back surgery Year: ______  ☐ Ovaries removed  ☐ Left  ☐ Right  Year: ______

☐ Breast surgery  ☐ Left  ☐ Right Year: ______  ☐ Stress test of heart Year: ______

☐ Cataract extraction  ☐ Left  ☐ Right Year: ______  ☐ Tonsils removed Year: ______

☐ Catheterization of heart Year: ______  ☐ Tubes tied Year: ______

☐ Gall bladder removed Year: ______  ☐ Uterus removed Year: ______

☐ Heart surgery Year: ______  ☐ Vasectomy Year: ______

Description of surgery or any other surgeries you have had: ____________________________

REPRODUCTIVE HISTORY

How many pregnancies have you had? ______  Number of live births: ______  Number of living children: ______

Number of C-Sections: ______  Number of miscarriages: ______  Number of still births: ______  Number of abortions: ______

Menopause (‘change of life’) since: _______________

IMMUNIZATION HISTORY

Are your childhood vaccinations up to date?  ☐ Yes  ☐ No  ☐ Unsure  Have you had the following vaccines?

Flu (this year)  ☐ Yes  ☐ No  Date: ______  Pertussis (“whooping cough”)  ☐ Yes  ☐ No  Date: ______

Hepatitis B  ☐ Yes  ☐ No  Date: ______  Shingles  ☐ Yes  ☐ No  Date: ______

Pneumonia (Prevnar)  ☐ Yes  ☐ No  Date: ______  Tetanus  ☐ Yes  ☐ No  Date: ______

Pneumonia (Pneumovax)  ☐ Yes  ☐ No  Date: ______  COVID  ☐ Yes  ☐ No  Brand: ______  Date: ______

Others: _______________  ☐ Yes  ☐ No  Date: ______

FAMILY MEDICAL HISTORY

Please indicate if your mother (m), father (f), sister (sis), brother (b), daughter (d), son (son) has a history of the following.

☐ Alcohol abuse  Who? ______  ☐ High blood pressure  Who? ______

☐ Anesthesia complications  Who? ______  ☐ High cholesterol  Who? ______

☐ Anxiety  Who? ______  ☐ Kidney disease  Who? ______

☐ Asthma  Who? ______  ☐ Lung problems  Who? ______

☐ Blood clots  Who? ______  ☐ Melanoma  Who? ______


☐ Cancer, other: _______________  Who? ______  ☐ Other mental illness  Who? ______

☐ Depression  Who? ______  ☐ Prostate cancer, how old: _______________  Who? ______

☐ Diabetes, how old: _______________  Who? ______  ☐ Seizures  Who? ______


☐ Eczema  Who? ______  ☐ Thyroid trouble  Who? ______

☐ Heart attack, how old: _______________  Who? ______  ☐ Other: _______________  Who? ______

If your father is deceased, how old was he when he died? ______  What did he die from? _______________

If your mother is deceased, how old was she when she died? ______  What did she die from? _______________

July 2021
SOCIAL HISTORY
Please indicate your marital or relationship status.
☐ Single   ☐ Married since: ________________________
☐ Not married, living together since: ______________
☐ Separated since: ______________
☐ Divorced since: ______________
☐ Widowed since: ______________
What is your gender identity? ________________________

SEXUAL HISTORY
Are you sexually active?  ☐ Yes  ☐ No
What is the gender of your sexual partner(s)? ______________
Age you became sexually active: ________________________
Number of sexual partners in the last year: ______________
What is your sexual orientation? ________________________

ALCOHOL & DRUG USE
On average, how many alcoholic beverages do you drink per week? ______________

Men under 65:  \[ \text{How many times in the past year have you had 5 or more drinks in a day?} \]
\[ \begin{array}{ll}
\text{None} & \text{1 or more} \\
\end{array} \]

Women (and men over 65):  \[ \text{How many times in the past year have you had 4 or more drinks in a day?} \]
\[ \begin{array}{ll}
\text{None} & \text{1 or more} \\
\end{array} \]

How many times in the past year have you used a recreational drug or a prescription medication for non-medical reasons?
\[ \begin{array}{ll}
\text{None} & \text{1 or more} \\
\end{array} \]

HEALTHY HABITS
In general, how many days do you exercise per week? ______________

On those days, how long do you exercise? ______________ minutes

When you exercise, what is the intensity?
\[ \begin{array}{ll}
\text{Mild (stretching or slow walking)} & \text{Moderate (brisk walking)} \\
\text{Heavy (jogging or swimming)} & \text{Vigorous (fast running or stair climbing)} \\
\text{Combination} & \\
\end{array} \]

TOBACCO USE
☐ I have never used tobacco
☐ I have smoked, started at age: ______________
☐ I still smoke ____ packs per day
☐ I quit ________ (date) but used to smoke ____ packs per day
☐ I have tried to quit ________ times
☐ I chew or use smokeless tobacco
☐ I vape or use e-cigarettes
☐ I am exposed to second-hand smoke

The following people make up my household.

<table>
<thead>
<tr>
<th>Name</th>
<th>Year born</th>
<th>Relation to me</th>
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REPRODUCTIVE LIFE PLANNING
Would you like to become pregnant in the next year?
☐ Yes ☐ No ☐ Okay either way ☐ Unsure
Are you using any method to prevent pregnancy?
☐ Yes ☐ No
If yes, what: __________________________________________
Do you use condoms? ☐ Yes ☐ No

COLORECTAL HEALTH
Date of most recent colonoscopy: __________________________
Date of other colorectal cancer screening: __________________

ADVANCED CARE PLANNING
Have you filled out forms to indicate your desires for end of life care?
Living Will: ☐ Yes ☐ No
Durable power of attorney for healthcare (“DPOA”): ☐ Yes ☐ No
If yes, who: __________________________________________

COMPREHENSIVE REVIEW OF SYSTEMS
Please check the boxes of any symptoms you have had in the past 2 weeks.

General
☐ Fatigue
☐ Fever
☐ Loss of appetite
☐ Unplanned weight gain
☐ Unplanned weight loss

Skin
☐ New sore or lesion
☐ Non-healing sores
☐ Rash

Eyes/Ears/Nose/Throat/Mouth
☐ Began wearing glasses or contacts
☐ Change in vision
☐ Bad teeth
☐ Dentures
☐ Frequent stuffy nose
☐ Hearing loss
☐ Hoarseness
☐ Nose bleeds
☐ Ringing in ears
☐ Seasonal allergies
☐ Sinus pain
☐ Snoring

Lungs
☐ Breathing problems
☐ Cough
☐ Coughing up blood
☐ Wheezing

Breasts
☐ Breast lump
☐ Breast pain

Cardiovascular
☐ Chest pain or pressure
☐ Heart beats fast
☐ Heart skips
☐ Short of breath with exercise
☐ Short of breath lying down
☐ Waking at night short of breath
☐ Swelling or edema

Gastrointestinal
☐ Abdominal pain
☐ Black tarry stool
☐ Blood in stool
☐ Change in bowel habits
☐ Constipation
☐ Diarrhea

Gastrointestinal, continued
☐ Difficulty swallowing
☐ Heartburn
☐ Nausea
☐ Vomiting

Genitourinary
☐ Bleeding after menopause
☐ Blood in urine
☐ Difficulty holding urine
☐ Difficulty urinating
☐ Excessive urination at night
☐ Pain or burning with urination
☐ Sexual health concerns
☐ Trouble with periods

Muscles and Skeleton
☐ Backache
☐ Muscle pain
☐ Painful joints

Endocrine
☐ Excessive thirst
☐ Hot flashes

Neurological
☐ Fainting or passing out
☐ Headaches
☐ Memory loss
☐ Numbness or tingling
☐ Sense of room spinning
☐ Tremor
☐ Unsteadiness or imbalance
☐ Weakness

Mental Health
☐ Change in sleep pattern
☐ Feeling nervous, anxious or on edge

Blood
☐ Easy bleeding
☐ Easy bruising
☐ Swollen glands

Other: __________________________________________

DEPRESSION SCREENING (PHQ-2)
Over the past two weeks, how often have you been bothered by the following problems?

Little interest or pleasure in doing things:
☐ Not at all ☐ Several days ☐ More than half of the days ☐ Nearly every day
☐ 0 ☐ 1 ☐ 2 ☐ 3

Feeling down, depressed or hopeless:
☐ Not at all ☐ Several days ☐ More than half of the days ☐ Nearly every day
☐ 0 ☐ 1 ☐ 2 ☐ 3

Patient Name: __________________________  Date of Birth: ________________
SLIDING SCALE DISCOUNT PROGRAM
Compassionate financial support

It is the policy of MAHEC to provide essential services for Medical, Behavioral Health, and Dental Care regardless of the patient's ability to pay. Discounts are offered based on family size and annual income.

The discount will apply to all essential services provided and billable by MAHEC. Services performed by outside organizations and equipment that is purchased from outside companies, including outside laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services, will not be covered under this policy. This form must be completed every 12 months or if your financial situation changes.

The application can be completed online by using the QR codes below, or you can request a paper application from any front desk team member.

These documents will need to be turned in before your application can be processed: Completed Application and Proof of Income

Applications need to be received within 30 days of your first appointment.

Family Health Centers
Financial Advocate
Phone: (828) 771-5502  |  Fax: (828) 579-4208
Mailing Address:
123 Hendersonville Rd, Asheville, NC  28803

Center for Psychiatry and Mental Wellness
Financial Advocate
Phone: (828) 771-5466  |  Fax: (828) 579-4212
Mailing Address:
125 Hendersonville Rd, Asheville, NC 28803

Ob/Gyn Specialists
Financial Advocate
Phone: (828) 771-5443  |  Fax: (828) 407-2639
Mailing Address:
119 Hendersonville Rd, Asheville, NC 28803

Dental Health Centers
Financial Advocate
Phone: (828) 398-5918  |  Fax: (828) 552-8691
Mailing Address:
123 Hendersonville Rd, Asheville, NC 28803

Internal Medicine
Financial Advocate
Phone: (828) 771-3507  |  Fax: (828) 579-3748
Mailing Address:
123 Hendersonville Rd, Asheville, NC 28803

If you have any questions regarding this program, please feel free to contact your Patient Financial Advocate.
## AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

**COMPLETE ALL SECTIONS, DATE, AND SIGN**

<table>
<thead>
<tr>
<th>Patient Name: ________________________________</th>
<th>Date of Birth: ________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>I authorize the use or disclosure of the above named individual’s health information as described below.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>The information is to be disclosed by:</th>
<th>And is to be provided to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME OF FACILITY: MAHEC Centralized Medical Records Department</td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Family Medicine ☐ OB/Gyn ☐ Internal Medicine</td>
</tr>
<tr>
<td></td>
<td>☐ Dental ☐ Psychiatry ☐ Community Pharmacy</td>
</tr>
<tr>
<td>ADDRESS: 121 Hendersonville Road</td>
<td></td>
</tr>
<tr>
<td>CITY/STATE: Asheville, NC 28803</td>
<td></td>
</tr>
<tr>
<td>PHONE #:</td>
<td>FAX #:</td>
</tr>
</tbody>
</table>

**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.**

<table>
<thead>
<tr>
<th>SIGNATURE OF PATIENT</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>SIGNATURE OF AUTHORIZED REPRESENTATIVE PATIENT, IF APPLICABLE (State relationship to Patient)</td>
<td>DATE</td>
</tr>
<tr>
<td>WITNESS TO SIGNATURE, IF APPLICABLE</td>
<td>DATE</td>
</tr>
</tbody>
</table>

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