

WELCOME TO OUR PRACTICE

We are happy you have chosen MAHEC Ob/Gyn Specialists for your care!

We are very proud of the quality care rendered by our team of providers that includes board certified physicians, maternal fetal medicine specialists, obstetrical and gynecological resident physicians, advanced practice nurse midwives and nurse practitioners. As your specialist, we are committed to providing you with the highest level of compassionate care. We will coordinate with your primary care provider when appropriate to ensure you receive the full spectrum of care you deserve.

OFFICE HOURS - Monday - Friday 8:00-5:00

If you have a concern, please call (828) 771-5500. A nurse will return the call the same day, as soon as possible. If you have an emergency, please tell the receptionist when you call so that a nurse can talk with you immediately.

AFTER HOURS

Nights, weekends, and holidays you may reach the physician on call by calling our office at (828) 771-5500 and selecting option #1 for the answering service. If you have a non-urgent issue, you can select option #2 to leave a voicemail message for us. Calls a returned the next business day.

MAHEC Ob/Gyn Specialists

Mary C. Nesbitt Biltmore Campus, 119 Hendersonville Road, Asheville, NC 28803

Phone: 828-771-5500 | Fax: 828-771-5454



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
 - o 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



☐ Non-Hispanic/Latino/Spanish

MAHEC Patient Registration Form

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

		Creek □ FHC Enka/Candler □ FHC Newbridge Brevard □ Psychiatry □ Deerfield □ Givens	
PATIENT INFORMATION			
Name:		Date of Birth:	
Mailing Address:		Birth Sex: □ Male □ Female	
•		SS#:	
•			
•			
Home Phone:	Cell Phone:	Work Phone:	
		to contact me or my guardian/legal representative to wide general health reminders and other information	
Special Hearing Needs:		Uses Wheelchair: □ Yes □ No	
Special Vision Needs:		Speech Impaired: ☐ Yes ☐ No	
		Veteran Status: ☐ Yes ☐ No	
Race (select one):	Gender Identity:	Marital Status:	
☐ Asian Indian ☐ Male		☐ Single	
☐ Chinese ☐ Female		☐ In a relationship	
☐ Filipino	☐ Transgender Male	☐ Partner	
☐ Japanese	☐ Transgender Female	☐ Married	
☐ Korean ☐ Other		☐ Separated	
☐ Vietnamese ☐ Choose not to disclose		☐ Divorced	
☐ Other Asian		☐ Widowed	
☐ Native Hawaiian	Sexual Orientation:		
☐ Other Pacific Islander ☐ Lesbian or Gay		Special Populations	
☐ Guamanian/Chamorro	☐ Heterosexual (or straight)	Migratory ☐ Yes ☐ No	
☐ Samoan	☐ Bisexual	Seasonal ☐ Yes ☐ No	
☐ Black/African American	☐ Something else	Homeless ☐ Yes ☐ No	
☐ American Indian/Alaska Native	☐ Don't know	Homeless Status (select one):	
☐ White	☐ Choose not to disclose	□ Not Homeless	
☐ More than one race	Preferred Language:	☐ Homeless Shelter	
File (2.1) (colored as a)	☐ English	☐ Transitional	
Ethnicity (select one):	Constale	☐ Doubling Up	
D Pussion		☐ Street	
☐ Puerto Rican	☐ American Sign Language	☐ Permanent Supportive Housing	
☐ Cuban	☐ Other:	☐ Other	
☐ Hispanic/Latino/Spanish	— · · · · · · · · · · · · · · · · · · ·		

EMERGENCY CONTACT INFORMATION	
Phone#:	
Phone#:	
i.edi ililorination only and is not used to	s determine specific patient manetal needs.
	Policy ID#:
	Policy Holder's DOB:
	Policy Holder's Birth Sex: Male Femal
ATION	
	Policy ID#:
	Policy Holder's DOB:
	Policy Holder's Birth Sex: 🗆 Male 🗀 Femal
INANCIAL POLICY	
e them to release medical and/o	e benefits directly to MAHEC and I authorize them to file or account information to my insurance, Medicaid, and/or ould my coverage change.
or major credit cards. I insurance will be filed for me. I AHEC with current and accurate ment plans. Which are medically appropriate. y responsibility to pay.	ductibles are expected on the date of service). However, it is my responsibility to know the details of my information. However, some of these may not be covered by my see of service and will bill me directly if the insurance does
	Phone#: Phone#: Phone#: Phone#: FINANCIAL POLICY ance, Medicaid, and/or Medicare them to release medical and/or claims. I agree to notify them shows a revice (if insured, co pays and de or major credit cards. Il insurance will be filed for me. If AHEC with current and accurate ment plans. Which are medically appropriate. By responsibility to pay.

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• 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

• Expects the parent or guardian to pay for all services rendered to their dependents.

result in being discharged from the practice.

I have read and understand the above.

Patient or Parent/Guardian Signature: ____

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, a answered. I understand if I choose not to sign this acknowledgment, MAHEC will and disclose my Protected Health Information (PHI) in accordance with MAHEC's	continue to provide services		
Patient or Parent/Guardian Signature:	Date:		
FOR OFFICE USE ONLY			
Primary Care Provider:			
Copy of insurance card obtained? Yes No		June 2023 Page 3 of 3	

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

CONSENT FOR TREATMENT

MRN #: _____



Who may we speak with?

This form will allow MAHEC to <u>discuss</u> 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.

Your name (please print)	
Your date of birth:	
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 #:
OI	R
I do not wish to list anyone at this time.	
Signature of patient, parent, or legal guardian	 Date



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
 - Proof of Income

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

Family Health Centers and Internal Medicine Financial Advocate

Phone: (828) 771-3507 | Fax: (828) 407-2640

Mailing Address: 123 Hendersonville Rd, Asheville, NC 28803

Center for Psychiatry and Mental Wellness Financial Advocate

Phone: (828) 771-3460 | Fax: (828) 820-8327

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



English



Español

MAHEC

Centralized Medical Records Department
121 Hendersonville Road, Asheville, NC 28803 | Business Office Phone: (828) 771-5489 | Fax: (828) 407-2637

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN				
Patien	t Name:	Date of Bir	th:	
I autho	orize the use or disclosure of the above named in	ndividual's health information as descr	ibed below.	
The in	formation is to be disclosed by:	And is to be provided to:		
	OF FACILITY:	MAHEC Centralized Medical Record Dental Dental Psychiatry	☐ Internal Medicine	
ADDR	ESS:	121 Hendersonville Road		
	STATE:	Asheville, NC 28803		
PHON				
i ne pi	urpose or need for this disclosure is:			
(includir	tand that the information released may include sensitive in grecords of a program that provides alcohol or drug abus use (sexual, physical, elder, spousal, etc.) abortion, sexual	se diagnosis, treatment, or referral, as defined	by federal law at 42 CFR Part 2),	
Inform	ation to be disclosed: (check appropriate box(es))			
	Standard release (last 3 years of notes, lab/x-ray	reports, med list, allergy list, immuniza	tion 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				
	stand that this authorization will expire 90 days from the sfollows.	date it is signed unless I have specified a diffe	erent expiration date or expiration	
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		