

#### 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

☐ Choose not to disclose

# **MAHEC Patient Registration Form**

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

#### **PATIENT INFORMATION** Legal Name: \_\_\_\_\_ Name you go by: \_\_\_\_\_\_ Date of Birth: \_\_\_\_\_ Pronouns: ☐ She/Her ☐ He/Him ☐ They/Them ☐ Other \_\_\_\_\_\_ Birth Sex: ☐ Male ☐ Female Mailing Address: \_\_\_\_\_ \_\_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ SS#: \_\_\_\_\_ Home County: \_\_\_\_\_ Email Address: \_\_\_\_ Home Phone: \_\_\_\_\_ Vork 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: Uses Wheelchair:** □ Yes □ No Race (select all that apply): **Marital Status:** Asian ☐ Single **Speech Impaired:** □ Yes □ No ☐ Asian Indian ☐ In a relationship ☐ Yes ☐ No **Veteran Status:** ☐ Chinese □ Partner ☐ Filipino ☐ Married **Gender Identity:** ☐ Japanese ☐ Male ☐ Separated ☐ Korean ☐ Female ☐ Divorced ☐ Vietnamese ☐ Transgender Male ☐ Widowed ☐ Other Asian ☐ Choose not to disclose ☐ Transgender Female Native Hawaiian/Other Pacific Islander ☐ Something else: \_\_\_\_\_ **Special Populations** ☐ Native Hawaiian ☐ Choose not to disclose Migratory ☐ Yes ☐ No ☐ Other Pacific Islander Seasonal ☐ Yes ☐ No **Sexual Orientation:** ☐ Guamanian/Chamorro Homeless ☐ Yes ☐ No ☐ Lesbian or Gay ☐ Samoan Homeless Status (select one): ☐ Heterosexual (or straight) ☐ Black/African American ☐ Not homeless ☐ Bisexual ☐ American Indian/Alaska Native ☐ Unhoused ☐ Something else ☐ White ☐ Transitional ☐ Don't know ☐ Choose not to disclose ☐ Doubling up ☐ Choose not to disclose ☐ Street Ethnicity (select all that apply): **Preferred Language for Your Appointment:** ☐ Permanent supportive housing ☐ Mexican/Mexican American/Chicano ☐ English ☐ Something else:\_\_\_\_\_ ☐ Puerto Rican ☐ Spanish ☐ Choose not to disclose ☐ Cuban ☐ Russian ☐ Hispanic/Latino/Spanish ☐ American Sign Language

Something else:

EMERGENCY CONTACT INFORM	ATION	MRN #:
	Phone#:	
nelationship.	Thones.	
IF PATIENT IS CHILD (UNDER 18)		
·		
Relationship:	Phone#:	
ANNUAL HOUSEHOLD INCOME	BEFORE TAXES	
	# of Individuals in Household:	
The income information above is used for sta	tistical information only and is not used to determi	ine specific patient financial needs.
PRIMARY INSURANCE INFORMA	ATION	
		Policy ID#:
		Policy Holder's DOB:
•		Policy Holder's Birth Sex: ☐ Male ☐ Femal
·		<u> </u>
SECONDARY INSURANCE INFOR	RMATION	
Insurance Company:		Policy ID#:
Policy Holder's Name:		Policy Holder's DOB:
Policy Holder's Relationship to Patier	nt:	Policy Holder's Birth Sex: 🗆 Male 🗀 Femal
Policy Holder's Address:		
ASSIGNMENT OF BENEFITS AND	FINANCIAL POLICY	
insurance on my behalf. I also author		fits directly to MAHEC and I authorize them to file unt information to my insurance, Medicaid, and/or y coverage change.
I understand that MAHEC:		
<ul> <li>Accepts cash, checks, debit card</li> <li>Expects Medicaid, Medicare and insurance coverage and provide</li> <li>Will work with me to establish page</li> </ul>	all insurance will be filed for me. Howeve MAHEC with current and accurate inform ayment plans.	er, it is my responsibility to know the details of my nation.
insurance plan and these will be	my responsibility to pay.	ver, some of these may not be covered by my

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\_\_\_\_ Date: \_\_\_\_

• 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: \_\_\_\_\_

health services, and services offered by lay health workers (e.g. doula, commodeemed necessary by the healthcare providers treating me at any MAHEC face emergency medical care from a physician or hospital, if needed. I understand limited to lab tests on blood, urine, and tissue, including drug screenings. I uninclude but are not limited to x-ray, ultrasound, and/or mammography. I und science and that diagnosis and treatment may cause injury or even death. I use treatment and/or procedures and the right to refuse any treatment or procedures.	cility. I voluntarily consent to allow MAHEC to seek d that diagnostic procedures may include but are not nderstand that diagnostic radiology procedures lerstand that the practice of medicine is not an exact understand I have the right to ask questions about my
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 Practice answered. I understand if I choose not to sign this acknowledgment, MAHEC and disclose my Protected Health Information (PHI) in accordance with MAHI	will continue to provide services to me and will use
Patient or Parent/Guardian Signature:	Date:
PATIENT STATUS FOLLOWING THREE YEAR ABSENCE  I understand that if I do not receive a medical or mental health service from a be considered a non-established patient for medical and mental health servi if I want to resume receiving care from a MAHEC provider. It also means that from other healthcare providers and will not retain or place any information year absence.	ices. That means I will have to re-establish as a patient MAHEC will not accept or retain medical records sent
Patient or Parent/Guardian Signature:	Date:
FOR OFFICE USE ONLY	
Primary Care Provider:	
Copy of insurance card obtained?   Yes   No	

I voluntarily consent to routine services, medical treatment(s), diagnostic radiology procedure(s), diagnostic lab(s), behavioral

**CONSENT FOR TREATMENT** 

MRN #: \_\_\_\_\_



Name:	
DOB: _	
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.

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	<b>!</b>
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 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



**English** 



Español

# **INCOMING TO MAHEC**

#### **MAHEC**

MRN:				

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**

COMPL	ETE ALL SECTIONS, DATE, AND SIGN				
Patien	tient Name:Date of Birth:				
I autho	rize the use or disclosure of the above named inc	dividual's health information as descr	ibed below.		
The inf	formation is to be disclosed by:	And is to be provided to:			
NAME	OF FACILITY:	MAHEC Centralized Medical Reco	•		
ADDRE	ESS:	121 Hendersonville Road			
CITY/S		Asheville, NC 28803			
PHONE	E #: FAX #: prose or need for this disclosure is:				
me pu	rpose of fleed for this disclosure is.				
records	and that the information released may include sensitive in of a program that provides alcohol or drug abuse diagnosis, ohysical, elder, spousal, etc.) abortion, sexual diseases like	, treatment, or referral, as defined by federal	law at 42 CFR Part 2), rape, abuse		
Informa	ation to be disclosed: (check appropriate box(es))				
	Standard release (last 3 years of notes, lab/x-ray i	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, tre Drug screen results and information Mental health notes Genetics testing	eatment, and related information nabout drug and alcohol use and treatm	ents		
	tand that this authorization will expire 90 days from the of follows.	date it is signed unless I have specified a di	fferent expiration date or expiration		
	tand that I may cancel this authorization at any time by no 3, and this authorization will cease to be effective on the o				
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.					
related o	cand that MAHEC will not condition treatment or eligibility or (2) provided solely for the purpose of creating Protected ng below, I acknowledge that I have read and under	Health Information for disclosure to a third p			
SIGNATURE OF PATIENT  DATE					
SIGNATURE OF AUTHORIZED REPRESENTATIVE PATIENT, IF APPLICABLE (State relationship to Patient)  DATE					
WITNESS	WITNESS TO SIGNATURE, IF APPLICABLE DATE				