



Name: _____

DOB: _____

MRN#: _____

Dear Patient,

Welcome to MAHEC! We are honored to be part of your healthcare journey. MAHEC is an Academic Health Center committed to providing high-quality, compassionate care while training the next generation of healthcare professionals. During your visits, you may be seen by resident physicians, dentists, or other trainees who work closely under the supervision of experienced clinicians. This collaborative model ensures you receive thoughtful, evidence-based care while contributing to the future of healthcare. This letter outlines what you can expect when communicating with our team and accessing our services.

FINANCIAL ASSISTANCE PROGRAM

We welcome all patients, regardless of income or insurance status, and have expanded our financial assistance programs to better serve our community.

- **Medical Clinics:** All patients are asked to complete a new patient information packet to help us determine eligibility for our updated Sliding Scale Discount Program, which is based on family income and size.
- **Community Pharmacies:** MAHEC offers in-house community pharmacies at our Biltmore and Enka/Candler locations that provide coordinated care for MAHEC patients. You do not have to be a MAHEC patient to use our pharmacy; however, patients seen in our clinics are eligible to participate in our exclusive medication discount program at the pharmacy.
- **Patient Financial Advocates** are here to help you apply for assistance and explore payment options if you are unable to pay your portion in full at the time of service. If you need help with prescription costs, you can request a referral to our Medication Access Team, who will assist you in navigating discounted options for your medications.

PATIENT PORTAL – YOUR PRIMARY COMMUNICATION TOOL

We encourage all patients to use the Follow My Health (FMH) patient portal for non-emergency communication and reviewing lab results.

If you do not have a portal account, you can request one at www.mahec.net/patientportalform. For help, contact the FMH Help Desk at support@followmyhealth.com or 888-670-9775 (Mon–Fri, 8am–8pm).

Please note: Our Dental Health Centers do not use the patient portal. For dental-related communication, please contact your dental office directly.

Portal Messages

- Non-urgent messages: you should receive a response within 3 business days.
- Urgent concerns: Please call the office directly.
- Emergencies: Call 911 or go to the nearest emergency room.

MEDICATION REFILLS

- Request routine prescription refills directly through your pharmacy.
- Refill requests: you should receive a response within 3 business days.
- New medications or certain refills may require a visit, especially for controlled substances or if monitoring labs are needed.
- A government-issued photo ID is required to pick up controlled substances at the pharmacy.

LAB RESULTS

- Results are available in the portal when they are received (typically within 5 business days).
- Critical results: You will be contacted within 24 hours.
- Follow-up visits may be needed to discuss certain results.

CANCELLATION AND LATE ARRIVAL POLICY

- Please give at least 24 hours' notice if you need to cancel or change your appointment. Cancellations made less than 24 hours of your scheduled appointment time will be marked as no-shows.
- If you arrive more than 10 minutes late, your appointment may need to be rescheduled.
- If you no-show two appointments in six months, you will only be able to schedule same-day appointments.

FORMS AND PAPERWORK

- Most forms require a dedicated visit (e.g., non-pregnancy FMLA, disability, Medicaid evaluations).
- Work and school excuses may be printed in the office or sent via your portal the same day as your visit.
- Forms we do not complete include SSI disability, medical cannabis attestation, and DOT physicals.
- Please call our office if you have questions about your form and to schedule a visit.

GENERAL EXPECTATIONS

- Please bring the following to every visit: your insurance card and a valid photo ID, any relevant medical records, and a current list of medications (including drug names, dosages, and how long you have been taking them).
- Office hours vary – please refer to our website to view the hours of each clinic.
- After-hours services are available for urgent needs by calling the clinic directly. Non-urgent requests made after hours will be addressed the next business day.
- For billing, referrals, or medical record questions, please call our office and follow the prompts.

We look forward to partnering with you in your care. Thank you for choosing MAHEC!

Warm regards,
MAHEC Health Centers

By signing, I acknowledge that I have read and understand the expectations outlined in this document.

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

Legal Name: _____

Name you go by: _____ Date of Birth: _____

Pronouns: She/Her He/Him They/Them Other _____ Birth Sex: Male Female

Mailing Address: _____

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 all that apply):

- Asian
 - Asian Indian
 - Chinese
 - Filipino
 - Japanese
 - Korean
 - Vietnamese
 - Other Asian
- Native Hawaiian/Other Pacific Islander
 - Native Hawaiian
 - Other Pacific Islander
 - Guamanian/Chamorro
 - Samoan
- Black/African American
- American Indian/Alaska Native
- White
- Choose not to disclose

Ethnicity (select all that apply):

- Mexican/Mexican American/Chicano
- Puerto Rican
- Cuban
- Hispanic/Latino/Spanish
- Non-Hispanic/Latino/Spanish
- Choose not to disclose

Uses Wheelchair: Yes No

Speech Impaired: Yes No

Veteran Status: Yes No

Gender Identity:

- Male
- Female
- Transgender Male
- Transgender Female
- Something else: _____
- Choose not to disclose

Sexual Orientation:

- Lesbian or Gay
- Heterosexual (or straight)
- Bisexual
- Something else
- Don't know
- Choose not to disclose

Preferred Language for Your Appointment:

- English
- Spanish
- Russian
- American Sign Language
- Something else: _____

Marital Status:

- Single
- In a relationship
- Partner
- Married
- Separated
- Divorced
- Widowed
- Choose not to disclose

Special Populations

Migratory Yes No

Seasonal Yes No

Homeless Yes No

Homeless Status (select one):

- Not homeless
- Unhoused
- Transitional
- Doubling up
- Street
- Permanent supportive housing
- Something else: _____
- Choose not to disclose

EMERGENCY CONTACT INFORMATION

MRN #: _____

Name: _____

Relationship: _____ Phone#: _____

IF PATIENT IS CHILD (UNDER 18)

Responsible Party Name: _____

Relationship: _____ Phone#: _____

ANNUAL HOUSEHOLD INCOME BEFORE TAXES

_____ # of Individuals in Household: _____

The income information above is used for statistical information only and is not used to determine specific patient financial needs.

PRIMARY INSURANCE INFORMATION

Insurance Company: _____ Policy ID#: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Policy Holder's Relationship to Patient: _____ Policy Holder's Birth Sex: Male Female

Policy Holder's Address: _____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____ Policy ID#: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Policy Holder's Relationship to Patient: _____ Policy Holder's Birth Sex: Male Female

Policy Holder's Address: _____

ASSIGNMENT OF BENEFITS AND FINANCIAL POLICY

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: _____

PATIENT STATUS FOLLOWING THREE YEAR ABSENCE

I understand that if I do not receive a medical or mental health service from a MAHEC provider for more than three (3) years, I will be considered a non-established patient for medical and mental health services. That means I will have to re-establish as a patient if I want to resume receiving care from a MAHEC provider. It also means that MAHEC will not accept or retain medical records sent from other healthcare providers and will not retain or place any information about me in my medical record following my three (3) year absence.

Patient or Parent/Guardian Signature: _____ Date: _____

FOR OFFICE USE ONLY

Primary Care Provider: _____

Copy of insurance card obtained? Yes No



Name:	_____
DOB:	_____
MRN#:	_____

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



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

**Ob/Gyn Specialists
Financial Advocate**

Phone: (828) 771-5443 | Fax: (828) 407-2639

Mailing Address:

119 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

**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

If you have any questions regarding this program, please feel free to contact your Patient Financial Advocate

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

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 Centralized Medical Records Department <input type="checkbox"/> Family Medicine <input type="checkbox"/> OB/Gyn <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Dental <input type="checkbox"/> Psychiatry <input type="checkbox"/> Community Pharmacy
ADDRESS:	121 Hendersonville Road
CITY/STATE:	Asheville, NC 28803
PHONE #: _____ FAX #: _____	

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.