



**MAHEC**  
Ob/Gyn Specialists  
at Franklin



## 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 - Thursday 8:00-5:00**

If you have a concern, please call (828) 634-4565. 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) 634-4565 and selecting option #1 for the answering service. If you have a non-urgent issue, you can select option #2 to leave a voice mail message for us. Calls are returned the next business day.

**MAHEC Ob/Gyn Specialists at Franklin**  
56 Medical Park Drive, Franklin, NC 28734

**Phone:** 828-634-4565 | **Fax:** 828-407-2593



## 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](http://www.mahec.net)**



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





# MAHEC Patient Registration Form

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

- Psychiatry  Internal Medicine  FHC Biltmore  FHC Cane Creek  FHC Enka/Candler  FHC Newbridge  Ob/Gyn Biltmore  
 Pharmacy at Enka  Pharmacy at Biltmore  Ob/Gyn Franklin  Women's Care Brevard  Deerfield  Givens

## 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:

\_\_\_\_\_

Uses Wheelchair:  Yes  No

Special Vision Needs:

\_\_\_\_\_

Speech Impaired:  Yes  No

Veteran Status:  Yes  No

### 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

### Marital Status:

- Single
- In a relationship
- Partner
- Married
- Separated
- Divorced
- Widowed

### Sexual Orientation:

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

### 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

### Ethnicity (select one):

- Mexican/Mexican American/Chicano
- Puerto Rican
- Cuban
- Hispanic/Latino/Spanish
- Non-Hispanic/Latino/Spanish

### Preferred Language:

- English
- Spanish
- Russian
- American Sign Language
- Other: \_\_\_\_\_

**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: \_\_\_\_\_

**FOR OFFICE USE ONLY**

Primary Care Provider: \_\_\_\_\_

Copy of insurance card obtained?  Yes  No







# Patient History Questionnaire

OB/GYN ASHEVILLE    OB/GYN FRANKLIN    WOMEN'S CARE BREVARD

Please answer the following questions so that we can include this information in your chart.

What is the main reason for your visit today? \_\_\_\_\_  
\_\_\_\_\_

## ALLERGIES

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## CURRENT MEDICATIONS (include dosage)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## MEDICAL HISTORY (check all that apply)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Acid reflux (GERD)  | <input type="checkbox"/> High blood pressure (hypertension) | <b>Cancer:</b> <input type="checkbox"/> Breast |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> High cholesterol                   | <input type="checkbox"/> Cervical              |
| <input type="checkbox"/> Bipolar             | <input type="checkbox"/> Hyperthyroid                       | <input type="checkbox"/> Colon                 |
| <input type="checkbox"/> Blood clot (DVT/PE) | <input type="checkbox"/> Hypothyroid                        | <input type="checkbox"/> Ovarian               |
| <input type="checkbox"/> Depression/anxiety  | <input type="checkbox"/> Migraines                          | <input type="checkbox"/> Uterine               |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Osteopenia                         | <b>Other:</b> _____                            |
| <input type="checkbox"/> Emphysema/COPD      | <input type="checkbox"/> Osteoporosis                       | _____  |
| <input type="checkbox"/> Heart attack        | <input type="checkbox"/> Stomach ulcers                     | _____  |
| <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Stroke                             | _____  |

## SURGICAL HISTORY (check all that apply)

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Bariatric (sleeve/bypass) | <b>Breast:</b> <input type="checkbox"/> Biopsy                                    | <b>Hysterectomy:</b> <input type="checkbox"/> Vaginal | <b>Ovary:</b> <input type="checkbox"/> Left |
| <input type="checkbox"/> Bladder                   | <input type="checkbox"/> Lump   | <input type="checkbox"/> Laparoscopic                 | <input type="checkbox"/> Right              |
| <input type="checkbox"/> Bowel/appendix            | <input type="checkbox"/> Mastectomy   | <input type="checkbox"/> Abdominal                    | <input type="checkbox"/> Both               |
| <input type="checkbox"/> Ectopic pregnancy         | <input type="checkbox"/> Reduction  |   |   |
| <input type="checkbox"/> Gallbladder               |   |   |   |
| <input type="checkbox"/> Heart                     |   |   |   |
| <input type="checkbox"/> Hip/knee/foot             | <b>Cesarean section:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, how many? _____                               |   |
| <input type="checkbox"/> Laparoscopy               | <b>Other:</b> _____   | _____   |   |
| <input type="checkbox"/> Shoulder/elbow/hand       | _____   | _____   |   |
| <input type="checkbox"/> Thyroid                   | _____   | _____   |   |
| <input type="checkbox"/> Tonsils                   | _____   | _____   |   |
| <input type="checkbox"/> Tubal ligation            | _____   | _____   |   |

## FAMILY HISTORY (check all that run in your family)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Acid reflux (GERD)  | <input type="checkbox"/> High blood pressure (hypertension) | <b>Cancer:</b> <input type="checkbox"/> Breast |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> High cholesterol                   | <input type="checkbox"/> Cervical              |
| <input type="checkbox"/> Bipolar             | <input type="checkbox"/> Hyperthyroid                       | <input type="checkbox"/> Colon                 |
| <input type="checkbox"/> Blood clot (DVT/PE) | <input type="checkbox"/> Hypothyroid                        | <input type="checkbox"/> Ovarian               |
| <input type="checkbox"/> Depression/anxiety  | <input type="checkbox"/> Migraines                          | <input type="checkbox"/> Uterine               |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Osteopenia                         |  |
| <input type="checkbox"/> Emphysema/COPD      | <input type="checkbox"/> Osteoporosis                       | <b>Other:</b> _____                            |
| <input type="checkbox"/> Heart attack        | <input type="checkbox"/> Stomach ulcers                     | _____  |
| <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Stroke                             | _____  |

## PREGNANCY HISTORY

Date:	Outcome:	Weight:	Problems with pregnancy/delivery:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Outcome examples include: Vaginal, C-section, Miscarriage, Ectopic, Termination, etc.

## SOCIAL HISTORY

- Are you now:  Single  Married  Widowed  Divorced  Separated
- Do you work?  Yes  No If yes, what do you do? \_\_\_\_\_
- Do you smoke?  Yes  No If yes, how much? \_\_\_\_\_
- Do you drink alcohol?  Yes  No If yes, how much? \_\_\_\_\_
- Do you use any illegal drugs?  Yes  No If yes, what? \_\_\_\_\_
- Have you ever been a victim of abuse?  Yes  No

## HEALTH MAINTENANCE

- When was your last Pap? \_\_\_\_\_ Was it normal?  Yes  No
- When was your last mammogram? \_\_\_\_\_ Was it normal?  Yes  No
- When was your last colonoscopy? \_\_\_\_\_ Was it normal?  Yes  No
- When was your last bone scan (DEXA)? \_\_\_\_\_ Was it normal?  Yes  No
- When was your last STD test? \_\_\_\_\_ Was it normal?  Yes  No



## 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.

<b>The information is to be disclosed by:</b>	<b>And is to be provided to:</b>
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.**

<b>SIGNATURE OF PATIENT</b>	<b>DATE</b>
<b>SIGNATURE OF AUTHORIZED REPRESENTATIVE PATIENT, IF APPLICABLE (State relationship to Patient)</b>	<b>DATE</b>
<b>WITNESS TO SIGNATURE, IF APPLICABLE</b>	<b>DATE</b>

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