

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



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

-	
MAH	HEC

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 #:
OF	ł
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.

		andler 🗆 FHC Newbridge 🗖 Ob/Gyn Biltmore		
Pharmacy at Enka Pharma	cy at Biltmore 디 Ob/Gyn Franklin 디 W	omen's Care Brevard Deerfield Givens		
PATIENT INFORMATION				
		_ Date of Birth:		
Mailing Address:		_ Birth Sex: 🗆 Male 🗖 Female		
City:	State: ZIP:	SS#:		
Home County:	Email Address:			
Home Phone:	_ Work Phone:			
		contact me or my guardian/legal representative to e general health reminders and other information		
Special Hearing Needs:		_ Uses Wheelchair: 🗆 Yes 🗆 No		
Special Vision Needs:		Speech Impaired: Yes No		
Special vision needs.				
		_ Veteran Status: 🛛 Yes 🗆 No		
Race (select all that apply):	Gender Identity:	Marital Status:		
Asian	🗖 Male	□ Single		
🗆 Asian Indian	Female	□ In a relationship		
Chinese Transgender Male		□ Partner		
🗖 Filipino	Transgender Female	□ Married		
Japanese	□ Something else:	_		
🗖 Korean	Choose not to disclose	Divorced		
□ Vietnamese		□ Widowed		
Other Asian	Preferred Pronoun (She/Her, He/Him,			
Native Hawaiian/Other Pacific Islander	They/Them etc.):	Special Populations		
Native Hawaiian		– Migratory 🛛 Yes 🗆 No		
Other Pacific Islander	Sexual Orientation:	Seasonal 🛛 Yes 🗆 No		
🗖 Guamanian/Chamorro	Lesbian or Gay	Homeless 🛛 Yes 🖾 No		
🗖 Samoan	Heterosexual (or straight)	Homeless Status (select one):		
Black/African American		Not homeless		
American Indian/Alaska Native	□ Something else	🗖 Unhoused		
□ White	Don't know	Transitional		
Choose not to disclose	Choose not to disclose	🗖 Doubling up		
		□ Street		
Ethnicity (select all that apply):	Preferred Language:	Permanent supportive housing		
Mexican/Mexican American/Chicano	□ English	□ Something else:		
🗖 Puerto Rican	□ Spanish			
🗖 Cuban	☐ Russian			
Hispanic/Latino/Spanish	🗖 American Sign Language			

Something else:_____

- □ Hispanic/Latino/Spanish
- □ Non-Hispanic/Latino/Spanish
- Choose not to disclose

EMERGENCY CONTACT INFO	MRN #:		
Name:			
Relationship:	Phone#:		
IF PATIENT IS CHILD (UNDE	R 18)		
Responsible Party Name:			
Relationship:	Phone#:		
ANNUAL HOUSEHOLD INCO	OME BEFORE TAXES		
	# of Individuals in Household:		
The income information above is used	for statistical information only and is not used to determine s	pecific patient financial needs.	
PRIMARY INSURANCE INFO		Policy ID#:	
•		Policy Holder's DOB:	
		Policy Holder's Birth Sex: 🗆 Male 🗆 Female	
Policy Holder's Address:			
SECONDARY INSURANCE IN	IFORMATION		
Insurance Company:		Policy ID#:	
Policy Holder's Name:		Policy Holder's DOB:	
Policy Holder's Relationship to F	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: __

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	CURR	CURRENT MEDICATIONS (include dosage)					
MEDICAL HISTORY (check al	l that apply)						
Acid reflux (GERD)	🗆 High	blood pressure (hypertension)	Cancer:	🛛 Breast		
🗆 Asthma	🛛 High	cholesterol			Cervical		
🗆 Bipolar	🗆 Нуре	rthyroid			Colon		
Blood clot (DVT/PE)	🗆 Нуро	othyroid			🛛 Ovarian		
Depression/anxiety	🗆 Migra	aines			□ Uterine		
Diabetes	🗆 Osteo	Osteopenia		Other: _			
Emphysema/COPD	🗆 Osteo	□ Osteoporosis					
□ Heart attack	🗆 Stom	□ Stomach ulcers					
□ Heart disease	□ Strok	e					
SURGICAL HISTORY (check a	all that apply)						
Bariatric (sleeve/bypass)							
🗖 Bladder	Breast:	🛛 Biopsy	Hysterectomy:	🗆 Vagir	nal	Ovary:	🗆 Left
□ Bowel/appendix		🗆 Lump		🗆 Lapai	roscopic		🗆 Right
Ectopic pregnancy		□ Mastectomy	/	□ Abdominal □ Bo		🛛 Both	
□ Gallbladder		□ Reduction					
□ Heart							
□ Hip/knee/foot	Cesarea	an section: 🗆 \	′es □No If yes, h	ow many?			
Laparoscopy							
□ Shoulder/elbow/hand	Other: .						
□ Thyroid							
□ Tonsils							
□ Tubal ligation							

FAMILY HISTORY (check all that run in your family)

🛛 Acid reflux (GERD)	□ High blood pressure (hypertension)	Cancer:	🗆 Breast
🗆 Asthma	□ High cholesterol		Cervical
🗆 Bipolar	□ Hyperthyroid		□ Colon
□ Blood clot (DVT/PE)	☐ Hypothyroid		□ Ovarian
Depression/anxiety	□ Migraines		Uterine Uterine
Diabetes	Osteopenia	Other:	
Emphysema/COPD	□ Osteoporosis		
🗖 Heart attack	□ Stomach ulcers		
□ Heart disease	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:	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

Mailing Address: 119 Hendersonville Rd, Asheville, NC 28803

Ob/Gyn Specialists

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

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

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

COMPLETE ALL SECTIONS, DATE, AND SIGN

Patien	t Name:	Date of Bi	rth:	
I authorize the use or disclosure of the above named individual's health information as described below.				
The in	formation is to be disclosed by:	And is to be provided to:		
	OF FACILITY:	MAHEC Centralized Medical Reco	•	
ADDR	ESS:	121 Hendersonville Road		
CITY/S	STATE:	Asheville, NC 28803		
PHON				
l unders records	Irpose or need for this disclosure is: tand that the information released may include sensitive ir of a program that provides alcohol or drug abuse diagnosis physical, elder, spousal, etc.) abortion, sexual diseases like	s, treatment, or referral, as defined by federa	l law at 42 CFR Part 2), rape, abuse	
Inform	ation to be disclosed: (check appropriate box(es))			
	Standard release (last 3 years of notes, lab/x-ray Only information related to <i>(specify)</i> :			
	Only the period of events from:			
	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				
	tand that this authorization will expire 90 days from the follows.		fferent expiration date or expiration	
l unders NC 2880 it.	tand that I may cancel this authorization at any time by n 13, and this authorization will cease to be effective on the	otifying in writing the MAHEC Privacy Officer date notified except to the extent action has	already been taken in reliance upon	
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.				
SIGNAT	JRE OF PATIENT		DATE	
SIGNAT	URE OF AUTHORIZED REPRESENTATIVE PATIENT, IF APPLI	CABLE (State relationship to Patient)	DATE	
WITNES	S TO SIGNATURE, IF APPLICABLE		DATE	

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