DURHAM FAMILY MEDICINE

2400 Broad Street, Suite 1 Durham, NC 27704 **Phone**: 919-220-9800 **Fax**: 919-220-9500
www.durhamfamilymedicine.net

Authorization for Release of Information

I authorize:

Facility Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: ( ) _____ Fax: ( ) _____

To Disclose/Release to:

Facility Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: ( ) _____ Fax: ( ) _____

The Protected Health Information of:

Patient's Legal Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Pt Date of Birth: _____ Medical Record Number: _____

Treatment Dates: _____

Information to be Disclosed (Please check information requested):

___Face Sheet	___Discharge Summary	___ History and Physical
___Consultations	___ Physician Orders	___Emergency Dept. Notes
___Medication/Graphic Sheets	___Progress Notes	___Operative/Procedure Notes
___Pathology Report	___Pictures	___Lab Reports
___Xray	___ Other _____	

DURHAM FAMILY MEDICINE

2400 Broad Street, Suite 1 Durham, NC 27704 **Phone**: 919-220-9800 **Fax**: 919-220-9500
www.durhamfamilymedicine.net

I acknowledge that the data released **MAY INCLUDE** material that is protected by law. My initials below authorize the release (if applicable) of information pertaining to:

___ Mental Health	___Drugs & Alcohol
___HIV/AIDS & other communicable diseases	___Genetic Testing

The purpose of the use or disclosure is (check the following that apply):

___ Attorney/Legal	___ Continued Patient Care	___ Social Services/Disability
___ Personal Use	___ Insurance	___ Other: _____

I understand that:

- I may revoke this authorization at any time.
- The revocation will not apply to information that has already been released in response to this authorization.
- The revocation will not apply to my insurance company and that the law provides my insurer with the right to contest a claim under my policy.
- If I revoke this authorization, I must do so in writing.
- The procedure for revoking this authorization is to present my written revocation to the Health Information Management Department.

I also understand that:

- I may refuse to sign this authorization.
- Durham Family Medicine will **not** condition the patient's treatment (or any payment, enrollment in a health plan, or eligibility for benefits) on receiving my signature on this authorization.

I have been informed and understand that information disclosed pursuant to this authorization may be subject to redisclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information will no longer be protected under federal medical privacy law.

I understand a fee may be charged for copying the protected health information.

Unless otherwise revoked, this authorization will expire automatically in ninety (90) days from the date of signature.

_____ _____
Signature of Patient Date
-OR-

_____ _____
Signature of Authorized Representative Date

_____ _____
Witness Date

Please explain the representative's authority to act on behalf of the patient:

_____

Health History Questionnaire:

DURHAM FAMILY MEDICINE

Name_____ Date of birth_____

Address_____

Local phone number_____ Alternative phone number_____

Please describe what problem or concern brought you to our office today:

☐Primarily to establish care

☐Other (please briefly describe)_____

Special Communication Needs:	
Language preference:	
If 'yes' to any of the questions below, how can we assist?	
Visual impairment ☐Yes ☐No	Cognitive impairment ☐Yes☐ No
Hearing impairment ☐ Yes ☐No	Sensory impairment ☐Yes ☐No
Speech impairment ☐Yes ☐ No	Other:

Personal Health History		Previous Surgical Procedures	
Please check past or current problems or conditions		Please check if you have had any of the following	
Condition	Condition	Procedure	Year
☐Hypertension	☐Seizures	☐Heart surgery	
☐High cholesterol	☐Headaches	☐Carotid artery surgery	
☐Diabetes	☐Stroke	☐Vascular surgery / stent	
☐Heart attack or angina	☐Prostate problem	☐Abdominal aneurysm repair	
☐Irregular heart rhythm	☐Breast problem	☐Hysterectomy	
☐Congestive heart failure	☐Urinary tract infections	☐Gallbladder removed	
☐Asthma	☐Osteoarthritis	☐Appendix removed	
☐Emphysema or chronic bronchitis	☐Cancer (Please list type)	☐Tonsillectomy	
☐Pneumonia	☐Thyroid problem	☐Joint replacement	
☐Gastroesophageal reflux disease	☐Bleeding disorder	☐Breast cancer surgery	
☐Stomach ulcer	☐Addiction Issues	☐Prostate cancer surgery	
☐Kidney problems	☐Depression or anxiety	☐Hernia	
☐Liver disease/hepatitis	☐Mental Illness	☐Pacemaker	
☐Colon cancer	☐Other (please describe)	☐ Other (please describe)	
☐Bowel/digestive problem			

Social History:
Please circle appropriate answers below and provide explanations where appropriate
Marital status:☐Single ☐Married ☐Divorced ☐Widowed ☐Life Partner
Education level: ☐ Did not Graduate ☐ High School ☐ Some College ☐ Bachelor's Degree ☐ Master's Degree or Higher
Occupation: Occupational concerns: ☐Stress ☐Hazardous substances ☐Heavy lifting
How stressful would you rate your current living situation: (Circle number) No stress 0 1 2 3 4 5 6 7 8 9 10 Very Stressful
Are there financial concerns that affect your ability to seek healthcare? ☐ No ☐Yes If yes, describe below
Are there any religious or cultural factors that you would like us to take into account when planning your healthcare?

Current Health Concerns			
Please check problems or conditions that you are CURRENTLY experiencing			
☐Chest pain	☐Rectal bleeding	☐Eye pain	☐Nervousness
☐Shortness of breath	☐Black/tarry stools	☐Loss of vision	☐Pain in testicles
☐Wheezing	☐Weight loss	☐Double vision	☐Loss of libido
☐Cough	☐Weight gain	☐Memory loss	☐Impotence
☐Coughing up blood	☐Loss of appetite	☐Ringing in ears	☐Breast pain
☐Sore throat	☐Difficulty swallowing	☐Pain in ears	☐Breast discharge
☐Nasal congestion	☐Diarrhea	☐Nose bleeds	☐Other (please describe below)
☐Irregular heartbeat	☐Constipation	☐Hoarseness	
☐Fast heartbeat	☐Painful urination	☐Easy bleeding	
☐High blood pressure	☐Blood in urine	☐Easy bruising	
☐Low blood pressure	☐Urine frequency	☐Rash	
☐Lightheadedness	☐Decrease in urine flow	☐Changes in mole	**Females - Please complete**
☐Dizziness/fainting	☐Urine leakage	☐Sore that won't heal	Menstrual flow:
☐Abdominal pain	☐Headache	☐Fatigue/lethargy	☐Reg. ☐ Irreg. ☐Pain/cramps
☐Heartburn	☐Weakness	☐Insomnia	Days of flow __ Length of cycle__
☐Indigestion	☐Loss of strength	☐Forgetfulness	1st day of last period_____
☐Ankle swelling	☐Balance problems	☐Depression	☐Pain or bleeding after sex
☐Nausea	Pain, weakness, or numbness in		Number of pregnancies ___
☐Vomiting	☐Arms ☐Hips ☐Back		Miscarriages___
☐Vomiting blood	☐ Legs ☐Neck ☐☐Shoulders		Birth control method _____
☐Change in bowel habits	☐Hands ☐Feet		

Family History			
Relationship	Living Y/N	Age	Major Medical Problems and/or Cause of Death
Father			
Mother			
Siblings			
Children			

Specifically have any of your relatives had the following conditions				
Condition	Relative		Condition	Relative
☐Mental illness			☐Chemical dependency	

Allergies:	
Please list any allergies to medications or foods	

Medications:	
Please list any medications that you take including over the counter medications, herbs, and supplements. Include dose and frequency	

Health Maintenance:				
Please check whether you have had the following preventive services and enter the year of the service				
Immunizations	Year		Tests	Year
Tetanus vaccine / Tdap☐Yes ☐No			Pap smear/pelvic ☐Yes ☐ No	
Pneumonia vaccine ☐ Yes ☐No			Mammogram ☐Yes ☐No	
Influenza vaccine ☐Yes ☐No			Bone dexa☐Yes ☐No	
Shingles vaccine ☐Yes ☐No			Colonoscopy ☐Yes ☐No	
			Prostate test ☐Yes ☐No	

Specialty Providers:	
In order that we can best coordinate your care, please list any medical providers you see outside of this practice and list the year that you last saw them	
☐Eye doctor	☐Nephrologist
☐Cardiologist	☐Psychiatrist
☐Oncologist	☐Allergist
☐Urologist / Gynecologist	☐Vascular
☐Gastroenterologist	☐Pulmonologist
☐Endocrinologist	☐Other

Health Behaviors:	
Tobacco use: ☐Never ☐Quit (when)_____ ☐Current smoker	
If current smoker how many packs per day for how many years_____	
Alcohol intake: ☐No ☐Yes If yes how many drinks/how often_____	
Illicit drug use (including marijuana, cocaine, steroids): ☐Never ☐Past ☐Current	
If past or current drug use describe:	
Exposure to secondhand smoke ☐Yes ☐No	Wear a seatbelt ☐Yes ☐No
Eat a diet high in fruits and vegetables ☐Yes ☐No	See a dentist at least once a year ☐Yes ☐No
Get 30 minutes of exercise 5 times a week ☐Yes ☐No	Wear sunscreen ☐Yes ☐No

Advance Care Planning:
Do currently have, or would you like information on, any of the following items
Living Will: ☐ Have☐ Don't Have☐ Want Information
Durable Power of Attorney: ☐ Have☐ Don't Have☐ Want Information
DNR Order:☐ Have☐ Don't Have☐ Want Information
Other:☐ Have☐ Don't Have☐ Want Information

Urinary Incontinence Assessment

Do you experience leaking in the following situations?

	Not at all	A little	Sometimes	A lot
During daily activities (work, household task)	☐	☐	☐	☐
During physical activities (walking, swimming, or other exercise)	☐	☐	☐	☐
During recreational activities (movies, hobbies)	☐	☐	☐	☐
During social activities (going out with friends, family visits)	☐	☐		☐
During car trips	☐		☐	

In the Past few Weeks:

Have you frequently experienced the need to urinate?	☐☐☐☐
Have you experienced leaking before an urgent need to urinate?	☐☐☐☐
Have you experienced leaking on effort, such as when sneezing, coughing, jumping, laughing, or during physical activity?	☐☐☐☐
Have you experienced a pressing or immediate urge to urinate?	☐☐☐☐
Have you noticed a change in your urination frequency?	☐☐☐☐
Do you need to urinate more than 8 times every 24 hours?	☐☐☐☐
Do you have to get up more than twice during the night to urinate?	☐☐☐☐
Do you sometimes have to strain to urinate?	☐☐☐☐

Fall Risk Screening

In the last 12 months have you fallen?	☐ Yes ☐ No ☐ Unsure
If yes, how many times?	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+
Were you injured as a result of this fall?	☐ Yes ☐ No ☐ Unsure

Mood Screening

A person's mood can have a strong influence on their health status and overall wellbeing.
Over the past 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things	Feeling down, depressed, or hopeless
☐ Not at all	☐ Not at all
☐ Several days	☐ Several days
☐ More than half the days	☐ More than half the days
☐ Nearly every day	☐ Nearly every day

Health Literacy Questionnaire

Many times in healthcare staff and providers use words that are unfamiliar to the general population. Please rate the following questions on a scale of 1 to 10; 1 being strongly disagree and 10 being strongly agree

I feel that I have a thorough understanding of the instructions that my doctors and nurses give me about my health	1 2 3 4 5 6 7 8 9 10
I feel that I remember the instructions given to me at my doctor's office when I get home	1 2 3 4 5 6 7 8 9 10
I feel that I have a strong understanding of medical language	1 2 3 4 5 6 7 8 9 10

Patient Signature:_____ Date:_____

Pediatric Health History Questionnaire (0-17 YO):

DURHAM FAMILY MEDICINE

Child's name_____ Date of birth_____

Mother's name: _____ Father's name:_____

Siblings names and ages: _____

Address_____

Pregnancy and Birth History	
Mother's age at birth:	Father's age at birth:
Did mother have any of the following during pregnancy?	
☐ Fever or rash	☐ Tobacco use (how much)
☐ Group B strep	☐ Alcohol use (how much)
☐ Sugar in urine / diabetes	☐ Street drug use (what type)
☐ High blood pressure	☐ Medication use (prescription or over-the-counter - list below)
☐ Anemia	
☐ Infections (if yes what type and how were they treated)	

Family History			
Relationship	Living Y/N	Age	Major Medical Problems and/or Cause of Death
Father			
Mother			
Siblings			

Specifically have any of the child's relatives had the following conditions				
Condition	Relative		Condition	Relative
☐ Diabetes			☐ Kidney problems	
☐ Cancer			☐ Heart disease	
☐ Seizures			☐ Stroke	
☐ Allergies/asthma			☐ Anemia	
☐ Bleeding problems			☐ HIV	
☐ High blood pressure			☐ Skin problems	
☐ Lung disease			☐ Chemical dependency	
☐ Mental illness			☐ Other:	

Are there any religious or cultural factors that you would like us to take into account when planning your child's healthcare?

Newborn History		
Birth Weight:	Birth length:	Head Circumference:
Born on time? ☐ Early ☐ Late How much:		
Type of delivery ☐ Vaginal ☐ C-section (why):		
How old was baby when she/he left the hospital?		
During the first week of life did the patient have any of the following		
☐ Feeding trouble	☐ Seizures	☐ Fever
☐ Excess vomiting	☐ Breathing trouble	☐ Receive antibiotics
☐ Jaundice (yellow skin)	☐ Need of oxygen	☐ Diarrhea
☐ Cyanosis (blueness)	☐ Blood transfusion	☐ In intensive care unit

Past Medical History		
Where has child gone for check-ups previously:		
Date of last medical checkup:		
Date of last dental check-up:		
Is your child up-to-date on immunizations? Please supply immunization records.		
Has your child had any of the following		
☐ Chicken pox	☐ Wears glasses	☐ Asthma
☐ Measles	☐ Heart murmur	☐ Allergies
☐ Mumps	☐ Kidney or bladder infection	☐ Broken bones
☐ Frequent ear infections (>4 year)	☐ Bed wetting (>5 years old)	☐ Head injury
☐ Frequent throat infections (>4 year)	☐ Diabetes	☐ Seizures
Has your child ever been hospitalized or had surgery? If yes, list age and reason:		
Has your child ever been on medication regularly? If yes, list medication(s) and reason:		
Do you have any concerns about your child's development? If yes, please describe:		

Allergies	
Please list any allergies to medications or foods	

Medications	
Please list any medications that your child takes including over the counter medications, herbs, vitamins and supplements. Include dose and frequency	

Specialty Providers
In order that we can best coordinate your child's care, please list any medical providers the child sees outside of this practice and list the year that they last saw them

Health Literacy Questionnaire	
Many times in healthcare staff and providers use words that are unfamiliar to the general population. Please rate the following questions on a scale of 1 to 10; 1 being strongly disagree and 10 being strongly agree	
I feel that I have a thorough understanding of the instructions that my doctors and nurses give me about my child's health	1 2 3 4 5 6 7 8 9 10
I feel that I remember the instructions given to me at my child's doctor's office when I get home	1 2 3 4 5 6 7 8 9 10
I feel that I have a strong understanding of medical language	1 2 3 4 5 6 7 8 9 10

Parent Signature:_____ Date:_____

DURHAM FAMILY MEDICINE

Patient Registration Form

Social Security #_____ Today's Date:_____

Name:_____ Date of Birth:_____

Address:_____
Street

_____
City, State, Zip Code

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Email:_____

Circle One **Sex:** Male Female **Marital Status:** Single Married Divorced Other

Patient's Employer:_____

Employer's Address:_____
Street, City, State, Zip

Employer's Phone #:_____

How did you hear about us? (circle one) friend, newspaper, yellow pages, dentist/doctor

Other: _____

BILLING AND INSURANCE INFORMATION

Name of Insurance Company:_____

Membership #:_____ Group #:_____

Name of Policy Holder:_____ Date of Birth (policy holder):_____

SS# (policy holder):_____

Employer of Policy Holder:_____

Secondary Insurance:_____

Membership #:_____ Group #:_____

Name of Policy Holder:_____ Date of Birth (policy holder):_____

FAMILY MEMBERS

	Name	Sex	Date of Birth	Relationship
Female Head of Household				
Male Head of Household				
Child/Dependent				
Child/Dependent				
Child/Dependent				

_____
Signature of Person Completing This Form Date

DURHAM
FAMILY
MEDICINE

Notice of Privacy Policies

As requested by the Federal privacy regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), effective April 14, 2003.

This summary briefly describes how **Durham Family Medicine** may use and disclose your Protected Health Information (PHI) to carry out our treatment, payment activities, healthcare operations and for the purposes that are permitted or required by law. It also summarizes your rights to access and control your PHI.

Our Responsibilities:

We are required by law to maintain the privacy of your PHI. In accordance with the HIPPA Privacy Regulations, we have the right to use and disclose your PHI for treatment, payment activities and health care operations as explained in the Notice of Privacy Practices. We are most likely to use and/or disclose your PHI for these functions.

Additionally, we may use or disclose your PHI as permitted and required by law. For example, we may use or disclose your PHI for public health activities, legal proceedings, or enforcement purposes.

Your Rights:

You have the following rights regarding your PHI:

- You have the right to request that Durham Family Medicine (DFM) communicate with you in an alternative manner or at an alternative location.
- You have the right to request that DFM restrict the PHI we use or disclose about you for treatment, payment or health care operations.
- You have the right to inspect and copy your PHI that is contained in a designated record set.
- You have the right to request an amendment if you believe that your PHI is incorrect or incomplete.
- You have the right to request an accounting of certain disclosures of your PHI that are for reasons other than treatment, payment or health care operations.
- You have the right to receive a paper copy of the DFM HIPPA Notice of Privacy Practices.
- You have the right to authorize disclosures of your PHI for reasons other than treatment, payment, or health care operations.

Complaints:

You may complain to us if you believe we have violated your privacy rights. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services.

DURHAM
FAMILY
MEDICINE

I acknowledge that I was given a copy of the HIPAA Notice of Privacy Policies from Durham Family Medicine. It explains how health information about me may be used.

_____

Patient's name

_____

Signature of Patient or Responsible Party Date

Contact Information:

May we call you at?

Home **YES** **NO**

May we leave a message on your home answering machine? **YES** **NO**

Work **YES** **NO** **N/A**

May we leave a message at work ? **YES** **NO**

Cell Phone **YES** **NO** **N/A**

May we leave a message on your cell phone? **YES** **NO**

If we cannot reach you, is there any person(s) who has your permission to receive information and answer questions on your behalf? If so, please list:

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

_____

Signature of Patient or Responsible Party Date

*Note: If you have joint custody of your child, both parents are entitled to have access to the child's records.

DURHAM
FAMILY
MEDICINE

CANCELLATION AND NO SHOW POLICY
EFFECTIVE 9/2/2014

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours notice. This will allow patients to be scheduled in that slot.

Office appointments which are cancelled within less than 24 hours notification may be subject to a **$25.00** cancellation fee. Procedure and Physical cancellations require at least a 72 hour notice. Without proper notification, they may be subject to a **$50.00** cancellation fee.

Patients who do not call to cancel or reschedule an office visit will be considered a **no show**. Patients may be subject to a **$25.00** fee for office appointments and **$50.00** for procedure/physicals.

Patients who cancel less than 24 hours in advance or **no show** two (2) or more times will receive a last chance letter. Once you have received a last chance letter and proceed to **no show** or cancel less than 24 hours before an appointment, you will be dismissed from the practice and denied any future appointments.

The cancellation and **no show** fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that special, unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. If you have questions or concerns about our cancellation and **no show** policy please contact our practice manger directly at **(919) 317-4549**.

DURHAM
FAMILY
MEDICINE

Durham Family Medicine is committed to the success and quality of your medical care and is honored to be your medical home. For your convenience, we have provided some general information about our policies and what you can expect from the services we offer. Please let us know if you have any additional questions or concerns.

Personal information: We verify insurance cards and request updated demographic information at each visit. This will ensure that we process accurate billing for you and your insurance company. If you do not have your insurance card available at the time of the visit, we may ask that you reschedule your appointment until you can present your card. If you have recently had a change in address, or have a new contact phone number or e-mail address, please offer that information at the time of check in.

Visiting our practice: We strive to provide a quiet and peaceful area for every patient waiting for an appointment. For that reason, we ask that no cell phones or video games be used while in the building; particularly in the waiting area, lobby and exam rooms. Parents are expected to monitor their children's behavior, thereby ensuring that all visitors experience a calm environment while waiting to see their provider. As a courtesy to all, we ask that patients bring no more than 1-2 family members when visiting us.

When children need to see the physician: Parents or legal guardians must accompany all patients who are minors and sign a statement accepting responsibility for the account. Minors between the ages of 15-17 who are able to come by themselves must have permission in writing from a parent or legal guardian to have treatment of any type unless related to pregnancy or possible venereal disease. The legal guardian or parent must also be available by phone for questions and possible consent to treat. A minor is considered anyone under the age of 18. Patients 18 and older may be considered financially responsible for payment when seen without a parent or guardian present.

Missed appointments: As a courtesy, we attempt to contact every patient to remind them of their appointment in advance. However, it is the responsibility of the patient to arrive for their appointment on time. Cancellations should be received 24 hours in advance. Patients who have missed three or more appointments within a 12-month period will be dismissed from the practice.

Financial responsibility: As a patient, you are ultimately responsible for all services provided. Because "coverage" depends on a variety of factors, it is extremely important that you fully understand what your coverage includes. We strongly recommend that you call your insurance carrier prior to your visit(s) with us, as they may require specified time periods between visits, such as annual physicals or certain diagnostic procedures.

Payments: We accept payment by cash, check, and most major credit cards.

Medication: New and prescription re-fills can be handled most directly if you check your prescription bottles before your appointment and request prescriptions during your visit with the provider. For all refill requests outside of appointments, please CONTACT YOUR PHARMACY. They will electronically notify us of your request. If your prescription for a maintenance medication is out of refills, you may be due for an appointment and/or necessary lab work. Narcotic pain medications require written prescriptions and will not be called into the pharmacy. NC law prevents us from refilling prescriptions for controlled substances (for pain, ADHD, etc.) without having a "face-to-face encounter" (office visit) with the patient in advance. **No narcotic prescriptions will be called in after-hours.**

Referrals: If our provider requests an urgent referral for diagnostic procedures, we will make every effort to process the referral on the same day if time allows. All referrals to specialists or for non-routine diagnostics will be handled within 5 working days. Please make sure our office staff has the best phone number to reach you in order to communicate your appointment information. We will make every effort to insure that the specialist accepts your insurance, but it is the patient's responsibility to confirm that a specialist is covered by his/her specific insurance plan prior to a visit.

Prior Authorization: Some insurance policies require prior authorization for radiology studies, referrals or certain prescription medications. This may cause a delay in scheduling appointments to facilities outside this office or obtaining non-urgent medications. Our office will file the appropriate forms in a timely manner, and you will be notified of the insurance company response promptly. Please allow 4-5 business days before calling our office to request a status update or approval confirmation.

Forms: Disability, employer, Family Medical Leave Act (FMLA), insurance forms, or any other paperwork that requires your provider's input can be very time consuming for both you and your provider. Please be sure to complete all required information prior to submission to your provider. You may be asked to schedule an appointment with your provider to review the requested information. If a provider agrees to complete a form which has been submitted outside a scheduled visit, a standard fee will be charged, depending on the amount of time required for review and completion. These fees are administrative fees and will not be filed for insurance reimbursement.

Patient Dismissals: We believe the physician/patient relationship to be a professional one based upon mutual trust. If a breakdown in this relationship occurs we reserve the right to refuse treatment. Reasons for dismissal include (not all-inclusive): Dishonesty, Aggressive or inappropriate behavior, Persistent non-compliance with treatment plans , Refusing to see and/or be treated by members of our staff, Illegal activity by patients or their caregivers , Patients or caregivers felt to be dangerous to self or others.

DURHAM
FAMILY
MEDICINE

Appointment Expectations

- **Established patients** who arrive no more than 10 minutes late will be checked in as usual. For example, if you have scheduled an appointment for 1:00 PM, you will be expected to arrive no later than 1:10 PM.

- Routine appointments for established patients are generally 20 minutes long. Patients who arrive more than 10 minutes late have missed their appointment and will be asked to re-book for another day.

- If you wish to wait, we can offer to check with the provider to see if they agree to work you in, which will mean waiting until the provider is available. However, the clinician may decide that it is not possible to see you later that day. You will then be asked to re-book the appointment.

- **All patients** are expected to bring a photo ID and current insurance card to each visit. **Failure to have this at check in will result in the appointment being rescheduled.**

- Established patients who miss **two** routine (20 minute time-slots) appointments without calling at least 24 hours in advance to cancel will receive a last chance letter. A third "No Show" appointment will result in dismissal from the practice.

- Established patients who miss **one** physical exam (40 minute time-slots) will receive a call or letter advising them of the missed appointment. If an established patient misses a second physical exam, the result will be dismissal from the practice.

****

- **New patients** must arrive <u>at least 15 minutes prior</u> to their scheduled appointment to complete all new patient paperwork. For example, if you have scheduled an appointment for 1:00 PM, you will be expected to arrive no later than 12:45 PM to allow time for paperwork completion and the check in process.

- All new patient appointments are at least 40 minutes long, and additional time to check in is necessary in order for us to obtain demographic and insurance information. **Patients who do not arrive prior to the actual appointment time will be asked to reschedule.**

- All patients are expected to bring a photo ID and current insurance card to each visit. **Failure to have this at check in will result in the appointment being rescheduled.**

There will be occasional emergencies which mean that a patient who is already in an exam room needs more time than anticipated. At check in, we will notify you if your provider is running late, will be happy to reschedule your appointment if it would be more convenient for you.