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 ____

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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

Date ______________________ Name ______________________________________ DOB __________________

Please answer every question on both sides of the following pages.

Please check any of the following medical problems that you have had.

- ☐Abn. Weight Loss
- ☐Abn. Weight Gain
- ☐Excessive Fatigue
- ☐Insomnia
- ☐Anemia
- ☐Cancer or Tumor

- ☐Glasses/ Contacts
- ☐Glaucoma
- ☐Cataracts
- ☐Other Problems with vision

- ☐Hearing Loss
- ☐Ear Problems
- ☐Ringing in Ears

- ☐Allergies
- ☐Frequent Sinus Infections

- ☐Dentures
- ☐Dental Problems
- ☐Recurrent Sores in Mouth

- ☐Angina
- ☐Frequent Chest Pain
- ☐Irregular Heartbeat
- ☐Heart Murmur

- ☐Rheumatic Fever
- ☐High Cholesterol
- ☐Heart Failure
- ☐Heart Attack
- ☐High Blood Pressure

- ☐Breathing Problems
- ☐Frequent Bronchitis
- ☐Emphysema
- ☐Pneumonia
- ☐Asthma

- ☐Heartburn
- ☐Ulcer Disease
- ☐Gallbladder Disease
- ☐Blood in Stool
- ☐Hepatitis
- ☐Diarrhea, Constipation, or other changes in bowel habits
- ☐Hemorrhoids
- ☐Abdominal Pain
- ☐Colon Polyp

- ☐Urinary Frequency
- ☐Bladder Infections
- ☐Prostate Problems
- ☐Urinary Incontinence
- ☐Kidney Problems

- ☐Arthritis or joint pain
- ☐Gout
- ☐Broken Bones

- ☐Rashes
- ☐Hives
- ☐Moles

- ☐Seizure
- ☐TIA
- ☐Stroke
- ☐Numbness
- ☐Weakness
- ☐Memory Loss
- ☐Headaches

- ☐Depression
- ☐Anxiety/ Panic Attacks
- ☐Suicide Attempt
- ☐Physical Abuse
- ☐Sexual Abuse
- ☐Mental Illness

- ☐Diabetes
- ☐Thyroid Disease
- ☐Sexually Transmitted Diseases

- ☐Abnormal Pap smear
- ☐Abnormal Mammogram
- ☐Breast Lump
- ____ #Pregnancies
- ____ Live Births
- ____ Miscarriages
- ____ Abortions

Have you been exposed to or do you have a close family member with...

- ☐HIV/AIDS
- ☐Hepatitis
- ☐TB

Other medical problems:

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________

List ***all*** surgeries you have had:

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________

List ***all*** medication allergies:

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________

List ***all*** medications, vitamins, and supplements you are currently taking:

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________
7. ______________________
8. ______________________

List ***all*** health care providers you have seen in the past or are currently seeing:

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________

(Continued on back)

Please list the last year in which you have had any of the following:

Physical Exam ______ Sigmoidoscopy/Colonoscopy (circle which one) ______ Cholesterol ______
Pap Smear ______ Stool Cards for Colon Cancer ______ Dental Visit ______
Mammogram ______ Rectal/Prostate Exam ______ Eye exam ______
Testicular Exam ______ Bone Density ______ Stress Test ______

Please list the last year in which you have had any of the following.

Tetanus ______ Pneumonia shot ______ Hepatitis B series ______
Flu shot ______ PPD (TB test) ______ Measles, Mumps, Rubella (MMR) ______

Please describe your use of tobacco products.

☐ None ☐ Cigarettes ☐ Smokeless Tobacco ☐ Pipe ☐ Cigars

How much do you or did you smoke ______ per day? For how many years ______?

Do you wish to quit? ☐ Now ☐ Soon ☐ Eventually ☐ Never

Have you quit? ______ When? ______

How much alcohol do you drink weekly on average? ______

Do you have a problem with alcohol? ☐ Yes ☐ No

Have you used illicit drugs (marijuana, heroin, cocaine, LSD, etc)? ☐ Yes ☐ No

How much caffeine do you drink daily (include coffee, tea, colas)? ______

Are you sexually active? ______ Are your partners male, female, or both? (circle)

Do you use contraception? ☐ None ☐ Rhythm ☐ Condoms ☐ Pill ☐ Vasectomy ☐IUD ☐Diaphragm ☐ Tubal Ligation

Do you practice safe sex? ☐ Never ☐ Sometimes ☐ Always

Have you ever had a blood transfusion? ☐ Yes ☐ No if Yes, what year ______?

What is your marital status? ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partner

Are you currently... ☐ Employed ☐ Unemployed ☐ Self Employed ☐ Retired

What is or was your occupation? ______

Please check which of the following behaviors you follow.

☐ Wear seatbelt ☐ Wear helmet while riding bike or motorcycle ☐ Smoke detector in house
☐ Fire Extinguisher in house ☐ Perform Self-Breast Exam Regularly ☐ Perform Self Testicular Exam
☐ Living Will or Advanced Directive ☐ Frequent exposure to animals (cats, dogs, other) ☐ Low Fat diet
☐ Exercise more than 3 times per week ☐ Gun in House ☐Gun secured by lock

Please check if there is a history of any of the following diseases in your family.

☐ Heart Disease ☐ Diabetes ☐ Colon Cancer ☐Osteoporosis ☐Prostate Cancer
☐ Breast Cancer ☐ Ovarian Cancer ☐ High Cholesterol ☐ Skin Cancer

Please fill in the following family history.

Age (or age at death) Medical Problems

Father ______
Mother ______
Siblings ______
______
Children ______
______

Patient Signature ______ Date ______

Physician Signature ______ Date ______

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

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.

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.

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 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.

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 at least 15 minutes prior 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.

Wellness Update

Patient_______________ Date of Birth_______________ Today's Date_______________

Do you experience any of these symptoms?	Yes	No
Runny Nose		
Itchy Nose		
Stuffy Nose		
Itchy Eyes		
Watery Eyes		
Frequent Sneezing		
Itchy Mouth/Lips/Throat		
Post Nasal Drip (drainage down the back of the throat, clearing throat)		

How often do you experience these symptoms?

- ☐ Occasionally (2-3 times per year)
- ☐ Over 3 times a year
- ☐ A few long periods of time per year (Spring, Summer, Fall, Winter)
- ☐ Most of the year

Do you take prescription or over-the-counter (OTC) medications for the management of your allergy symptoms? ☐ Yes ☐ No

Please indicate below symptoms/conditions you've experienced during the last 1 – 2 years

- ☐ Sinus related issues (sinus pressure/pain, headaches, sinusitis)
- ☐ Re-occurring Seasonal Colds
- ☐ Chronic colds (lasting longer than 2 months)
- ☐ Migraine Headaches
- ☐ Restless sleep, challenges sleeping through the night, snoring
- ☐ Consistent or Re-occurring coughing
- ☐ Feeling of fatigue, irritability, & restlessness
- ☐ Asthma
- ☐ Skin conditions (dry and/or itchy skin, etc...)

Patient Signature:_______________ Date:_______________

Patient Phone: _______________

FOR CAS USE ONLY:
Date of Last ENT Exam: