PATIENT REGISTRATION

Last Name: _____ First Name: _____ M.I. _____

Date of Birth: _____/_____/_____ Email address: _____

Primary phone number: _____-_____-_____ Alternative phone number: _____-_____-_____

Language:_____ Race:_____ Ethnicity: Hispanic___ Non-Hispanic___

How did you hear about us?_____

Have you been seen as a patient at this facility? ☐ Yes ☐ No

If yes, please complete questions below.

If no, complete HIPAA then go to New Patient Information.

Since your last visit, have you had any changes to the following	Yes	No	Comments (Please provide new information)
Home address			
Phone number			
Insurance Information			

HIPAA REQUIREMENT

This section is **REQUIRED** for the treatment of ALL (Adult & Minor) patients

Please list names of any person who may have access to patient's information.

Name: _____ Relationship to Patient: _____

Date of Birth: _____/_____/_____ Phone Number: _____

Name: _____ Relationship to Patient: _____

Date of Birth: _____/_____/_____ Phone Number: _____

Name: _____ Relationship to Patient: _____

Date of Birth: _____/_____/_____ Phone Number: _____

New Patient Information

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Age: _____ SSN: _____-_____-_____ Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer: _____ Employer Address: _____

Insurance Information

Primary Insurance Provider: _____ Policy Holder's Name: _____

Policy Holder's DOB: _____/_____/_____

Secondary Insurance Provider: _____ Policy Holder's Name: _____

Policy Holder's DOB: _____/_____/_____

Signature: _____ Date: _____

PATIENT FINANCIAL POLICY

Thank you for choosing Heritage Urgent & Primary Care. While your health and well-being are our primary concerns, we realize that the cost of healthcare is an issue for many patients. We offer the following information to help you understand our financial policies and aid you in planning for payment. Carefully review the information and please ask our staff if you have any questions.

INSURANCE

It is your responsibility to provide Heritage Urgent & Primary Care with current insurance information. We will ask you for your insurance card at your first visit and keep a copy for your records. We may request a copy at a later date in order to update your records, so please bring your insurance card to each visit. We will help you receive the maximum benefits your insurance allows, however, please remember that your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claims for you as primary care and provide necessary information, including primary and secondary insurance information changes, to your insurance company. Failure to provide complete insurance information may result in reduced insurance benefits for you.

Not all services are covered through all insurance plans. Some health plans select certain services that they will cover. Your insurance company will make the final determination of your eligibility and benefits. In the even that your health plan determines a service to be “not covered”, you will be responsible for the entire charge. Also, please be aware that if we are out-of-network for benefits, you will receive a bill and be responsible for the remaining balance. This balance is due upon receipt of your statement. In the event that you are unable to pay the balance in full, we encourage you to promptly contact our billing office at 866-557-2612 for assistance in creating a payment plan. Be aware that if your treatment requires biopsy or culture, you may receive a bill from a third party.

CO-PAYS

Co-payments may be required by your insurance plan. All co-payments must be paid prior to your appointment at check in. If you do not have your co-payment, your appointment may be rescheduled.

DEDUCTIBLES AND COINSURANCE

For patients who have insurance plans that have applicable deductibles and coinsurance, be aware that you will be responsible for payment of the deductible or coinsurance applicable to procedures. It is also the patient’s responsibility to check with insurance carrier concerning deductibles and coinsurance.

SELF-PAY ACCOUNTS

Self-pay accounts are for patients without insurance coverage. It may also include patients covered by insurance plans that Heritage Urgent & Primary Care is not in network with or patients without an insurance card on file. It is your responsibility to know if care at Heritage Urgent & Primary Care is covered by your plan. If there is a discrepancy of your information, you will be considered a self-pay patient until you provide information proving otherwise.

PAST DUE ACCOUNTS

If your account is past due, please contact the billing office at 866-557-2612, so that we can assist you with a payment plan. If your account has been referred to a collection agency or attorney, you must pay the balance in full, including any collection fees. If you require further treatment and your account is in collections, the full balance will be due, and you will be required to pay the cost of the next visit in full, prior to being seen.

RETURNED CHECKS

A fee may be required for returned checks. This amount will be applied to your account, in addition to the insufficient funds amount. Your account may be assigned "self-pay" status, requiring upfront payments following a returned check.

REFERRALS & PRE-AUTHORIZATIONS/NOTIFICATIONS/CERTIFICATES

Your insurance company may require a referral from another physician and/or a pre-authorization, notification, or certification. While it is your responsibility to obtain these, someone in the office will help you if necessary. Please make sure that all referrals are in our office prior to your visit. Failure to obtain these may result in a lower payment or no payment from your insurance company, and the balance will be your responsibility.

MINORS

The parent(s) or guardian(s) presenting the child for treatment is responsible for full payment and will receive the billing statements. In addition, we may pursue payment from a non-custodial parent of guardian.

PATIENT AUTHORIZATION, ACKNOWLEDGEMENT, AND AGREEMENT

I hereby authorize payment of health insurance benefits and, if applicable, government benefits directly to Heritage Urgent & Primary Care for services provided to me. I authorize the release of my healthcare information necessary to process my claims. I further authorize the release of my healthcare information to other healthcare providers, hospitals, and facilities involved in my treatment.

I understand, acknowledge, and agree that I am financially responsible for my deductible, co-pay, coinsurance, and any amount exceeding what my insurance company pays, except where exempt by contractual agreement. I understand that I am financially responsible for any balance remaining after my claim has been processed. I further upstand that I am responsible for complying with any requirements that my insurance carrier may have regarding referrals, prior approvals, and pre-authorizations.

I HAVE READ THE PATIENT FINANCIAL POLICY AND/OR IT HAS BEEN FULLY EXPLAINED TO ME. I CERTIFY THAT I UNDERSTAND ITS CONTENTS, AND THATI AM COMPETENT TO EXECUTE IT OR THAT I AM AUTHORIZED TO EXECUTE IT ON THE PATIENT'S BEHALF.

Print Patient's Name: _____

Signature: _____ Date: _____

Parent/Guardian Name (if applicable): _____

Parent/Guardian Signature: _____

Wake Forest
620 Dr. Calvin Jones Hwy., #212
Wake Forest, NC 27587
P: 919.761.5678
F: 919.761.5680

Leesville
13271 Strickland Rd. #120
Raleigh, NC 27613
P: 919.741.4677
F: 919.741.6349

CANCELLATION AND NO SHOW POLICY

We understand that situation arise that may require cancellation of your appointment. It is therefore requested that if you must cancel, please give us a 24-hour notice. This will enable other patients who are waiting for appointments to be scheduled in your slot.

Appointments that are cancelled with less than a 24-hour notification may be subject to a $50 cancellation fee.

Patient who do not show up for their scheduled appointment without a 24-hour cancellation notice are considered a NO SHOW and will be charged at $50 NO SHOW fee.

The cancellation and NO SHOW fees are the sole responsibility of the patient and must be paid in full before the patient can be seen again.

We understand that special circumstances may arise and cause you to cancel with less than a 24-hour notification. In this case, the cancellation fee MAY be waived by management approval.

Heritage Urgent & Primary Care believes that a good provider/patient relationship is based upon understanding and communication. Please sign below that you have read, understand, and agree to our Cancellation and No Show Policy.

Patient OR Guardian Signature: _____ Date: _____

Heritage Urgent and Primary Care

Acknowledgement of Receipt
Of Notice of Privacy Practices

Patient Name:_____ **DOB:**_____

I have received a copy of the Notice of Privacy Practices for the above-named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:
  _____
- ❑ Other:
  _____

Prepared By _____

Signature _____

Date _____

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Authorization to Release Health Information

Patient Information:

Name of Patient: _____ Date of Birth: _____

Address: _____

City, State, Zip: _____ Phone: _____

_____ **may release the following information:**

(Name of the entity)

☐ Healthcare information relating to the following treatment, condition, or dates: _____

☐ All healthcare Information

☐ Other: _____

Entity or person who will receive the information:

Name: _____

Address: _____

City, State, Zip: _____ Phone: _____

☐ **Send the information electronically. Email address:** _____

☐ For **email communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to move forward to allow email communications to occur.

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

Patient Rights:

- I have the right to revoke this authorization at any time by contacting our office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV.

This authorization will remain in effect until revoked by the patient.

Signature of Patient or Personal Representative: _____ Date: _____

*Description of Personal Representative's Authority (attach necessary documentation)

☐ Revoked by patient or personal representative on _____.
DATE

How revoked: ☐ orally (in person or via phone) ☐ in writing (place copy in patient's file)

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heritage URGENT & PRIMARY CARE

Health History Questionnaire:
☐ Initial ☐ Annual

Name_____ Date of birth_____

Address_____

Local phone number_____ Alternative phone number_____

Preferred Pharmacy_____ Pharmacy 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: Requires Updating Annually					
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**	
No Change Since Previous Year ☐		No Change Since Previous Year ☐	
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			

Fall Risk Screening: Requires Updating Annually for 65 years and older	
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**

Health Literacy Questionnaire:	
It is important to your provider that you understand the information related to your health. 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

Specialty Providers	
In order to 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
Please list all medications you are taking. Please include name, dose, and frequency.	

It is very important that you take the medication(s) your health care professional has given you. Please check the below boxes:

Are you unable to fill your prescription(s) because of the cost ☐ Yes ☐ No

Are you unable to fill your prescription(s) because of lack of transportation ☐ Yes ☐ No

Have you ever applied for any pharmacy assistance ☐ Yes ☐ No

Advance Care Planning	
Do you 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:

Allergies:	
Please List any allergies to medications or foods	

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	

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 dexascan ☐ Yes ☐ No	
Shingles vaccine ☐ Yes ☐ No			Colonoscopy ☐ Yes ☐ No	
Additional Vaccines taken since previous year: ☐ Yes ☐ No If yes, list vaccine name and date:			Prostate test ☐ Yes ☐ No	

Social History: Requires Updating Annually
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
Job concerns: ☐ Stress ☐ Hazardous substances ☐ Heavy lifting ☐ Transportation How stressful would rate your current job situation: (Circle number) Not Very Stressful 0 1 2 3 4 5 6 7 8 9 10 Very Stressful
How stressful would you rate your current living situation: (Circle number) Not Very Stressful 0 1 2 3 4 5 6 7 8 9 10 Very Stressful Do you fear for your safety in your current living situation? ☐ No ☐ Yes If yes, describe below:
Are there financial concerns that affect your ability: 1) to go to the doctor ☐ No ☐ Yes If yes, describe: 2) to obtain food and shelter ☐ No ☐ Yes If yes, describe:
Are there any religious or cultural factors that you would like us to consider when planning your healthcare? ☐ No ☐ Yes If yes, describe:

Health Behaviors: Requires Updating Annually for 11 years and older	
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

Urinary Incontinence Assessment: Requires Updating Annually for 65 years and older				
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	☐	☐	☐	☐

Mood Screening: Requires Updating Annually for age 11 and up	
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

Functional Assessment: Requires Updating Annually for 65 years and older				
Do you need assistance in the following areas?	Not at all	A little	Sometimes	A lot
Bathing, dressing and grooming	☐	☐	☐	☐
Daily activities (cooking, cleaning other household tasks)	☐	☐	☐	☐
Walking or driving	☐	☐	☐	☐
Communicating needs and feelings	☐	☐	☐	☐
Understanding directions	☐	☐	☐	☐
Keeping appointments, taking medications and performing other medical treatments	☐	☐	☐	☐
If yes to any of these questions, who helps with these activities?				

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	Females - Please complete
☐ Fast heartbeat	☐ Painful urination	☐ Easy bleeding	Menstrual flow:
☐ High blood pressure	☐ Blood in urine	☐ Easy bruising	☐ Reg. ☐ Irreg. ☐ Pain/cramps
☐ Low blood pressure	☐ Urine frequency	☐ Rash	Days of flow __ Length of cycle __
☐ Lightheadedness	☐ Decrease in urine flow	☐ Changes in mole	1st day of last period_____
☐ Dizziness/fainting	☐ Urine leakage	☐ Sore that won't heal	☐ Pain or bleeding after sex
☐ Abdominal pain	☐ Headache	☐ Fatigue/lethargy	
☐ Heartburn	☐ Weakness	☐ Insomnia	
☐ Indigestion	☐ Loss of strength	☐ Forgetfulness	
☐ Ankle swelling	☐ Balance problems	☐ Depression	
☐ Nausea	Pain, weakness, or numbness in		
☐ Vomiting	☐ Arms	☐ Hips	☐ Back
☐ Vomiting blood	☐ Legs	☐ Neck	☐ Shoulders
☐ Change in bowel habits	☐ Hands	☐ Feet	

Patient Signature:_____ Date:_____

Provider reviewed:_____ Date:_____