PREVENTION CENTER

"Getting to the heart of the matter before yours gives out"

Our Focus:
Identification of risk factors for heart attack, stroke, and diabetes through advance lab testing.

We create personal disease prevention plans based on the individual's characteristics.

To help us serve your best, please take a few moments to complete the attached NC Prevention Center Patient Registration Packet. This information will be confidential and will only be reviewed by NC Prevention Center providers or nurses, and your physician, physician assistant or nursing staff.

We look forward to partnering with you!
We engage patients in the office and on-line by providing them access to their health information and goals. We strive to be available to patients and answer any questions in a timely manner.

Let us help you discover your risk…

Frequently Asked Questions

Schedule/Cancel and Appointment
Appointments can be scheduled/cancelled by calling the office at **336-322-3352.** Please call the office in advance if there is a change or cancellation, preferably within 24 hours prior to your appointment.

Clinical Advice
During office hours, please contact the office with any questions or concerns. We are a busy practice, so please feel free to leave a message with our receptionists; we will return your call within 1 business day. If you are experiencing a medical emergency, please contact your Primary Care Provider or go directly to the closest Emergency Room.

Extended Hours
Our regular business hours are: Monday, Tuesday, and Wednesday from 8am – 4pm.

Sharing/Transferring Records
In order to provide optimal treatment and care to patients served in the Prevention Center, we would like access to patients' most recent labs, office visit notes/summaries, and any cardiac testing (and results).

What information do I need to bring to my appointment?
Please bring a copy of your photo ID, insurance card(s), and a list of your current medications. It is also helpful to bring a copy of your

prescription drug coverage, a list of other health care professionals that have treated you in the last year, details of any recent hospitalizations or ER visits, and any over-the-counter medicines or herbal remedies you may be taking.

What if I don't have insurance?

We are committed to serving all patients regardless of financial or insurance status. If necessary, we will work with you to make financial arrangements. However, please be aware that you will be required to pay your initial office visit upon check-in ($200 fee – not including labs of diagnostic testing).

How do I get a refill on my prescription?

Please contact your pharmacy to request a refill. Your pharmacist will send an electronic request to our office. This not only helps ensure prescription refill accuracy, but it is also the most time efficient for both our staff and, most importantly, our patients.

609 Professional Drive
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Tel: (336) 332-3352 Fax: (336) 599-2716

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Patient Information Data Sheet

Patient Information		
Last Name	First Name	Middle Name/Maiden Name
Sex (circle one) Male Female	Date of Birth	Social Security Number
Address	City	State/Zip Code
Home Phone	Cell Phone	Work Phone
Email	Race	Ethnicity (circle one) Hispanic Non-Hispanic
Primary Language	Marital Status	Occupation
Employer	Emergency Contact(s)	Relationship to you
Emergency Contact Phone	Emergency Contact Phone	
Responsible Party		
Name	SS# of Responsible Party	Birth Date of Responsible Party
Address	City, State, Zip Code	Phone Number(s)
Primary Insurance		
Carrier	Policy Number	Group Number
Policy Holder's Name	Policy Holder's SS#	
Secondary Insurance		
Carrier	Policy Number	Group Number
Policy Holder's Name	Policy Holder's SS#	

By signing below, I verify that the above information is correct to the best of my knowledge, and I acknowledge that I have received a copy of North Carolina Prevention Center's Notice of Privacy Practice.

_____ _____ _____

Patient (or Legal Guardian) Signature Date Staff Initial

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PREVENTION CENTER

Payment Policy

NC Prevention Center is committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. *A copy will be provided to you upon request.*

1. **Insurance**. We participate in most insurance plans, including Medicare and Medicaid. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments and deductibles**. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. **Non-covered services**. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare, Medicaid, or other insurers. You are responsible for the balance of the claim.

4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. **Coverage changes**. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. **Nonpayment**. If your account is over 90 days past due, you will receive a letter stating that you have to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____	_____	_____
Signature of patient or responsible party	Print Name	Date

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Patient Name:_____ DOB:_____

Address:_____

PATIENT PRIVACY DIRECTIVES

In our efforts to comply with HIPAA (Health Insurance Portability and Accountability Act), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and coworkers. You must inform us **in writing** of any changes in your directives.

If you would like our office to share medical information with anyone, please list them below.

_____ _____

PARENTS: List all individuals you authorize to bring your children (under 18) in for treatment.

_____ _____

Please provide the name/phone number of people that we may talk with/leave messages with regarding: (Mark "same" if it applies)

Appointments:

_____ _____

Medical Treatments/Test Results:

_____ _____

Billing/Insurance Issues:

_____ _____

Cell number that we may text health information to: _____

Name/Number of Emergency Contact: _____

I acknowledge that I have received a copy of the "Notice Of Privacy Practices" and that everything above is accurate.

_____	_____	_____	_____
Patient/Legal Representative Signature	Printed Name	Date	Staff Signature

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PATIENT REGISTRATION FORM: DISCLOSURES AND CONSENTS

Patient Name _____ DOB _____

Assignment of Insurance Benefits: I hereby authorize direct payment of my insurance benefits to North State Medical Center or the physician/provider individually for services rendered to my dependents or me by the physician/provider or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. **I understand and agree that I will be responsible for any co-pay or balance due that North State Medical Center is unable to collect from my insurance carrier for whatever reason.**

Medicare/Medicaid/Champus Insurance Benefits: I certify that the information given by me in applying for payment under these programs is correct. I hereby direct that payment of my dependent's or my authorized benefits be made directly to North State Medical Center or the physician/provider on my behalf.

Authorization to release non-public personal information: I certify that I have received and read a copy of the North State Medical Center Patient Information Privacy Policy. I hereby authorize North State Medical Center or the physician/provider individually to release any of my or my dependent's medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

Authorization to mail, call, or email: I certify that I understand the privacy risks of the mail, phone calls, and email. I hereby authorize a North State Medical Center representative or my physician/provider to mail, call, or email me with communications regarding my healthcare, including but not limited to such things as appointment reminds, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying North State Medical Center to that effect in writing.

Record Release: I hereby authorize the exchange/release of any information, via paper or electronic review by North State Medical Center with any providers, hospitals, and/or specialist(s) to whom I may receive care from, be referred for care, or to my insurance company to determine benefits and secure payment for services provided. North Carolina law requires us to inform you that your medical records, no matter when created may be released for the purpose of medical or scientific research unless a written objection is received.

Health Data Exchange: I authorize my insurer, health plan, or claims administrator and provider to share with each other my health information for care coordination and quality improvement purposes. This includes sharing my health information from treatment I have received at health care providers not related to **NC Prevention Center/NSMC**. My insurer, health plan, or claims administrator may also share the above information with a care system or accountable care organization in which **NC Prevention Center/NSMC** participates. If I do not want my health information shared for these purposes, I may opt out by initialing the statement below.

I **do not** want my health information shared for the purposes listed under "Health Data Exchange". _____**(initials)**

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Release of Records: I hereby authorize **NC Prevention Center/NSMC** to disclose specific health information from the records of the patient listed above to the persons listed below. **(Please list those persons who you give consent to be given your health information. Examples include: mother, husband, great aunt, grandfather, etc.…)**

Recipient Name	Recipient Name
Address	Address
Phone	Phone
Email	Email

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to submit a written request. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that if my record contains information relating to HIV infection, AIDS, or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment providers (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), services may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization.

Authorized Signature:_____ Date: _____

Consent to Treatment: I hereby consent to evaluation, testing, and treatment as directed by my North State Medical Center physician/provider or his/her designee.

_____ _____

Patient Signature (or Guarantor) (Relationship to patient, if applicable) Date

Please print Patient's/Guarantor's name:_____

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Patient Name: _____ Date of Birth: _____

How did you hear about us? (Circle one)

Newspaper Radio Family/Friend Billboard Other (specify) _____

Name of person who referred you (if any): _____

Allergies: ( ) None

( ) Medication Allergy/Type of Reaction: _____

( ) Food Allergy/Type of Reaction: _____

Current/Chronic Medical Conditions: ( ) None

Past Medical Problems: (Provide Year/Age): ( ) None

Surgeries: (Provide Year/Age): ( ) None

Tobacco Use: ( ) Yes ( ) No

Alcohol Use: ( ) None ( ) Occasionally/Rarely ( ) Weekly ( ) Daily

Illegal/Recreational Drug Use: ( ) Yes ( ) No

Print Name: _____ Date of Birth: _____

Highest Level of Education: _____

Currently Employed? ( ) Yes ( ) No Occupation: _____

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Patient Name:_____ Date of Birth:_____ Date: _____

Current Medications: (Please include birth control, herbal medications, vitamins, over-the-counter medications)

Pharmacy Name & Phone Number: _____

Medication	Strength/Dose	How Often Taking

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Patient Name:_____ Date of Birth:_____

Family History: ( ) No knowledge of family history

RELATION	AGE	HEALTH STATUS	DECEASED – Cause, Age at Death
Father			
Mother			
Siblings			
Children			

Please circle any conditions that apply to family members (children, parents, siblings, aunts, uncles, grandparents).

Asthma
Allergies
Arthritis
High Blood Pressure
Diabetes
Heart Disease
Bleeding/Clotting Disorder
Headaches
High Cholesterol
Seizures/Epilepsy
Stroke
Thyroid Disease
Tuberculosis
Chronic Lung Disease
Gallbladder Disease
Cancer
Liver Disease
Kidney Disease
Breast Cancer/Disease
Alcoholism/Substance Abuse
Mental Health Issues

Date of Last Physical: _____ Location: _____

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