Family Care
1413 Carpenter Fletcher Rd
Durham, NC 27713
(919) 544-6461

Sabrina M. Mentock, MD
Elaina L. Lee, MD
Sarada Schossow, PA-C

2017 Patient Demographics Form

Please provide the following demographic information for medical records at our office.

NAME _____ DATE OF BIRTH _____

ADDRESS _____ SSN _____

APARTMENT NUMBER _____ GENDER _____

CITY _____ STATE _____ ZIP _____ SEXUAL ORIENTATION _____

PRIMARY PHONE _____ OK to leave message? □ Y □ N MARITAL STATUS _____

WORK PHONE _____ OK to leave message? □ Y □ N ETHNICITY _____

ALTERNATIVE PHONE _____ OK to leave message? □ Y □ N PRIMARY LANGUAGE _____

EMAIL ADDRESS _____ OCCUPATION/ STUDENT STATUS _____

How did you hear about our office?

□ Angie's List □ Friend's Referral
□ Internet Search □ Drive By Our Office
□ Other: _____

Insurance Provider:

□ BCBS □ CIGNA
□ United Healthcare □ Aetna
□ Other: _____

EMERGENCY CONTACT _____ RELATIONSHIP TO PATIENT _____ PHONE NUMBER _____

PRIMARY PHARMACY _____ STREET NAME & CITY _____ PHONE NUMBER _____

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above listed insurance company and assign directly to Family Care, PA all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not they are paid by my insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

RESPONSIBLE PARTY SIGNATURE _____ RELATIONSHIP TO PATIENT _____ DATE _____

Family Care - *Patient Policy 2017*

We at Family Care strive to create a friendly and comfortable environment where your health is our primary concern. Please read this Patient Policy carefully so that you will understand our policies and avoid misunderstandings. All patients must fill out a "Patient Registration Form," HIPAA forms, and sign this Patient Policy before their first visit.

INSURANCE INFORMATION: It is essential that you notify us of any changes in insurance, whether it is a change in carrier or a change in plan, so please bring a current insurance card with you to every appointment. We must have the insurance card issued to you, or a photo copy of the card, to file your claim. Full payment for your service must be paid at the time of visit if you cannot provide the information needed to file your insurance claim. The patient and/or bearer of the insurance policy are ultimately responsible for payment for services not covered by their insurance plan.

PRIMARY INSURANCE CLAIMS: If Family Care has successfully filed your claim and not received finalization from your insurance company within 90 days, the remaining balance is the patient's responsibility to Family Care and it is up to the patient to obtain payment from their insurance.

Family Care is not responsible for knowing the coverage and limitations of your insurance plan. Because of the great diversity in plans, we must require that you, the patient and/or bearer of the insurance policy, be responsible for knowing and understanding the limitations of your insurance coverage. It is your responsibility to understand the following:

- Whether or not preventive care or other services are covered by your plan.
- Whether or not Family Care is a part of your insurance provider network.
- The total and remaining amounts of your co-pay and your deductible. If the information is unknown, you will be responsible for payment in full at the time of service. Any excess payment or adjustments by your insurance company will be refunded to you.
- Any other limitations in your coverage. Being familiar with your own coverage enables you to discuss alternative healthcare options, when available, with your doctor.

MEDICARE / SECONDARY INSURANCE CLAIMS: We do not file secondary insurance claims. If requested, you will be provided with the information and paperwork you will need to file a secondary claim through your insurance. We do file all Medicare claims; however, we do not accept assignment of Medicare claims. Payment must be made in full at the time of service for Medicare patients and payment from Medicare will be sent to you.

OUT OF NETWORK CLAIMS: If we are not contracted with your insurance company, we require full payment at the time of service. Patients with out-of-network insurance will be responsible for their bill in full at the time of checkout. It is the patient's responsibility to find out if we are in-network before being seen.

WORKER'S COMPENSATION / MOTOR VEHICLE ACCIDENTS: We do not process Workman's Compensation cases, or handle car accident cases where your benefits are not handled by your health insurance.

PATIENT UNDER AGE 18: The parents, guardian or adult accompanying the minor is responsible for payment. For unaccompanied minors, non-emergency treatment will be denied unless consent for treatment and charges have been pre-authorized by a parent or guardian.

SPECIALIST REFERRALS: To ensure the most comprehensive approach to your health care, Family Care may refer you to a specialist for additional tests or treatment. In selecting such a specialist, your physician considers the specialist's experience, qualifications, and skill. Unfortunately, it is impossible for us to know which providers accept each type of insurance plan. Family Care requires that you determine whether any physician to whom you are referred accepts your insurance prior to your visit.

FORMS: There is a minimum of a $10 charge for any forms that take extensive completion time during a visit and for any forms that are brought in to be filled out outside of a scheduled appointment.

PAYMENTS: Co-Pays must be paid at the time of service. *There will be a $10 Late Fee for non-payment at the time of visit.* We accept cash, checks and Visa/MasterCard as payment. New patients are required to pay with either cash or credit card. *There will be a $30 charge for all returned checks.* Accounts must be current to continue to receive care at our office. Patients may be refused care for non-emergency services if their account is 90+ days past due.

MISSED APPOINTMENTS: A charge will be made for broken appointments (unless 24 hour notice is given), or if you arrive more than 10 minutes late for your appointment. *A missed appointment charge is $25 and is due prior to your next appointment at our office.* This includes appointments cancelled on the same day of the exam or times where you arrive more than 10 minutes late for your scheduled appointment. This is necessary as such occurrences are detrimental to our business and other patient's waiting for an appointment. Family Care reserves the right to dismiss from the practice any patient who frequently misses scheduled appointments without prior notice.

PRESCRIPTION REFILL REQUESTS: *Please allow 2-3 days from the time of receipt for prescription refill requests.* Refill requests are primarily handled during an office visit. We do not fill controlled drugs over the phone or after office hours. We do not transmit controlled substances electronically, so a hard copy of all prescriptions for controlled substances must be picked up at our office. It is the patient's responsibility to have a list of the current medications that will need to be refilled prior to your follow up appointment. Failure to request a refill on a medication during an appointment may require the patient to return for another appointment.

LABORATORY CHARGES: Charges for blood collections will be filed with your insurance company and you may owe a balance for the charges. *You are required to pay $10 at the time of your blood draw at our office to cover specimen handling fees.* The laboratory will bill your insurance for the individual tests will still be filed with your insurance company by our outside laboratory.

PHONE CONSULTATIONS: *All patient phone conversations with Sabrina Mentock, MD, Elaina Lee, MD, and Sarada Schossow, PA-C may be billed as phone consultations.* This includes prescription refill requests and result notifications. If the patient has medical questions, concerns, or treatment options that are discussed and covered during the phone call, this appointment would be billed just like a regular office visit and any co-payments or deductibles owed by the patient will apply.

VACCINATIONS: Adult and child vaccines are offered through our office. Because of inconsistent insurance payment expectations, payment for certain vaccines is expected at the time of service. Patients are required to sign a vaccination waiver prior to receiving the vaccine.

Summary of Family Care's Patient Policy Agreement:

- Please expect to pay your copayment or deductible balance at the time of service.
- Please update the front desk staff with any changes to your address, phone number, demographics, and insurance plan prior to your visit.
- Please allow at least 48 hours for prescription refill requests.
- Medical claims that are denied because of provisions specified in the patient's insurance plan are the patient's responsibility to correct.
- Demographic and medical information may be released to specialists and other providers to coordinate your medical care.
- Prescriptions for controlled substances must be picked up in our office.
- You may be charged for phone conversations with a medical provider.
- You will be charged a $25 fee if you do not show up for your appointments on time.
- You will owe a $10 processing fee for all blood work done through our office.

I have read, understand, and agree with the above patient policy. You may request a copy of all signed documents for your personal reference.

Signature _____ **Date** _____

Summary of Privacy Practices for Family Care

A. We have a legal duty to protect health information about you.

B. We may use and disclose Protected Health Information (PHI) about you without your authorization in the following circumstances.
   a. We may use and disclose PHI about you to provide health care treatment to you.
   b. We may use and disclose PHI about you to obtain payment for services.
   c. We may use and disclose PHI about you for health care operations.
   d. We may use and disclose PHI when required to do so because of the law.
   e. You can object to certain uses and disclosures.
   f. We may contact you to provide appointment reminders.
   g. We may contact you with information about treatment, services, products or health care providers.

C. You have several rights regarding PHI about you.
   a. You have the right to request restrictions on uses and disclosures of PHI about you.
   b. You have the right to request different ways to communicate with you.
   c. You have the right to see and copy PHI about you.
   d. You have the right to request amendment of PHI about you.
   e. You have the right to a listing of disclosures we have made.
   f. You have a right to a copy of this Notice.

D. You may file a complaint about our privacy practices to 1413 Carpenter Fletcher Rd, Durham, NC, 27713.

E. Effective date of this notice is April 14, 2003.

F. We participate in an Organized Health Care Arrangement with providers in the UNC Health Alliance. We may use your PHI for our own health care operations and for those of the Organized Health Care Arrangement in which we participate. (Effective 4/1/2017)

Please review and sign the back of this notice.

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

The Patient hereby consents to the use or disclosure or his/her individually identifiable health information ("protected health information") by Family Care in order to carry out treatment, payment, or health care operations. The Patient should review the Facility's Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing this consent form.

Facility reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If the Facility does change the terms of its Notice of Privacy Practices, Patient may obtain a copy of the revised Notice by requesting in writing to 1413 Carpenter Fletcher Rd, Durham, NC 27713.

Patient retains the right to request that the Facility further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Facility is not required to agree to such requested restrictions; however, if the Facility does agree to Patient's requested restriction(s), such restrictions are then binding to the Facility.

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to the Facility in writing. The revocation shall be effective except to the extent that the Facility has already taken action in reliance on the Consent. Consent may be revoked upon written request to 1413 Carpenter Fletcher Rd, Durham, NC 27713.

The Facility may refuse to treat Patient if he/she (or an authorized representative) does not sign this Consent Form (except to the extent that the Facility is required by law to treat individuals). If Patient (or authorized representative) signs this Consent Form and then revokes Consent, the Facility has the right to refuse to provide further treatment to Patient as of the time of revocation Form (except to the extent that the Facility is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

Signature of Patient _____ Date_____

Print Patient's Name _____

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2017 Patient Financial Agreement

Please review the following financial information at our office.

This document is a breakdown of Family Care's financial policies and an explanation of potential charges you could owe related to services at our office. Actual amounts vary depending on the type of service provided and your health insurance coverage at the time of service. This list is not comprehensive and may be updated without prior notice.

Type	Description	Amount
Co-Payments / Co-Insurances	Amounts vary based on insurance coverage and must be made at the time of service.	Variable; based on insurance coverage
Deductibles	Patient is responsible for a certain amount of their health care expenses prior to insurance coverage paying for services. Amounts vary based on insurance coverage and must be made at the time of service.	Variable; based on insurance coverage
Phone Appointments	For medical care provided over the phone, in place of an in-person appointment.	Billed the same as an in-office appointment.
Missed Appointments	Missed appointments or appointments that are cancelled on the same date of the appointment.	$25
Blood Draws	Payment for specimen collection and processing. Additional charges from our laboratory may apply and will be billed directly from the laboratory.	$10
Completed Forms	Charge for form completion outside of a regular office visit or appointment.	$10
Returned Checks	A fee for a check that is returned by the bank for insufficient funds or any other reason that causes a check to be invalid.	$30
Late Fees	Non-payment of total balance in full at the time of service without prior approval from Family Care.	$10 initially + $10 for every three months of non-payment
Records Requests	Printed or electronic copies of patient's medical records.	Variable; $30 max; $10 min; based on quantity requested
Vaccinations	Vaccine administration.	Variable; based on vaccine
Laboratory Fees	Billed directly from our contracted laboratories.	Variable; based on service

I have read, understand, and agree with the above patient policy.

Signature _____ **Date** _____

HEALTH HISTORY
(Confidential)

Name_____ Today's Date_____

Age_____ Birthdate_____ Date of last physical examination_____

What is your reason for visit?_____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period_____

Date of last Pap Smear_____

Have you had a mammogram?_____

Are you pregnant?_____

Number of children_____

CONDITIONS Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

MEDICATIONS List medications you are currently taking

Pharmacy Name_____ Phone_____

ALLERGIES To medications or substances

(All information is strictly confidential)

FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (✓) if, your blood relatives had any of the following: Disease		Relationship to you
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart Disease, Strokes	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications if any

Have you ever had a blood transfusion? ☐ Yes ☐ No
If yes, please give approximate dates._____

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

HEALTH HABITS Check (✓) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Drugs	
	Other	

OCCUPATIONAL CONCERNS
Check (✓) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

X _____ _____
Signature Date

_____ _____
Reviewed By Date