Cary Healthcare Associates, P.A.

PATIENT REGISTRATION FORMS

Name____
Last First MI

Date of Birth: ________________ Age________ Social Security#____________________

Address: ____
Street City State Zip

Mailing Address if Different: ____

Home#_________________ Cell#_____________ Work#_______________ ext:_______

E-mail____

Emergency Contact Person and Phone #_______________________________________

Parent's Name (If Patient is a Minor):_____________________________________

Mother: __________________________ Father:____________________________

Patient Gender: ______ Marital Status: ______ Spouse Name (If applicable) ________________

Language: English Spanish Other:_______________

Race and Ethnicity: (Requested per Federal Guideline) Please circle one:

Ethnicity: Hispanic Non- Hispanic

Race: American Indian or Alaska Native Asian Native Hawaiian

Black or African American White Hispanic Other

Employer and Occupation:____

PRIMARY Insurance:____
Policy Holders Name:_____________________________ Date of Birth_______________
SS# of Policy Holder___________________ Relationship to Patient___________________
Policy#______________________________ Group#___________ Effective Date:_________

Secondary Insurance: ____
Policy Holders Name: _____________________________ Date of Birth_______________
SS# of Policy Holder___________________ Relationship to Patient___________________
Policy#______________________________ Group#___________ Effective Date: _________

I authorize Cary Healthcare Associates to send prescriptions and retrieve medication history electronically.
Patient's Signature ____

Pharmacy Name: ______________________ Pharmacy#______________________________

Cary Healthcare Associates, PA

301 Ashville Ave. Suite 111

Cary, NC 27518

Notice of Privacy Practices

Acknowledgement

____ I acknowledge that I have received a copy of the Notice of Privacy Practices.

____ I acknowledge that I have refused to accept a copy of the Notice of Privacy Practices.

Print Name:_______________________________________ Date:____________

Signature: ____

Signature of Patient (or authorized Representative)

CARY HEALTHCARE ASSOCIATES, PA
301 ASHVILLE AVENUE, SUITE 111 ◊ CARY, NC 27518
919-233-6000 TEL ◊ 919-233-6052 FAX

Compound Authorization for Release of Information

Federal Law states that we (Cary Healthcare Associates) cannot share your health information without your permission, except in certain situations.
Signing this form gives our office permission to share your health information with the person(s) you have indicated below.
The information disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal Law.
Payment, enrollment or eligibility benefits of your healthcare will not be affected if you sign this authorization, unless the disclosure is for eligibility or enrollment determinations.

I, ______________________________, give permission to Cary Healthcare Associates, PA to share the following information to the listed individual(s)/health care provider(s) below:
(please check all that apply)

- ☐ All of my Healthcare Information (including lab & imaging results, medications, messages, correspondence and personal health information)
- ☐ Financial/Billing Information
- ☐ HIV/STD testing information
- ☐ Psychotherapy notes and information

Name	Relationship to patient	Phone Number (if able)

I am aware I have the right to revoke this authorization at any time if I choose I do not want Cary Healthcare Associates to continue to share my information. I authorize this authorization until I revoke in writing by completing the revocation form. *(You may obtain the revocation form from the office)*

Signature of Patient or Personal Representative: ______________________________

Date: ______________________

Cary Healthcare Associates, P.A.

OFFICE POLICIES

FINANCIAL AGREEMENTS

I understand that I am financially responsible for ALL charges incurred at Cary Healthcare Associates regardless of third party liability (insurance carrier).

If your insurance requires that you pay a co-pay, deductible or co-insurance you are responsible for full payment at the time of the service.

If you have no insurance, you will be required to pay in full at the time of service.

I understand that I will receive 3 statements (1 each month) for any outstanding balances, and then will be placed into collections. A $20.00 "Collection Fee" will be added to my account to cover the fees imposed to Cary Healthcare Associates by the collection agency.

CANCELLATION POLICY

I understand that a 24 hour notice is required to cancel an appointment. A **$50.00** fee will be charged when an appointment is missed without a 24 hour notice on the 1st occurrence, **$100** on the 2nd occurrence, and **$150** for any subsequent visits for the calendar year.

CARY HEALTHCARE ASSOCIATES RESERVES THE RIGHT TO DISMISS FROM THE PRACTICE ANY PATIENTS WHO FREQUENTLY MISS SCHEDULED APPOINTMENTS.

I have read and understand the above office policies and agree to accept responsibility as described.

Patient's Signature: ______________________________ Date:____________

Signature of Personal Representative: ____________________ Date:____________

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Adult Health Questionnaire

Patient Name: ______________________________ Date: __________

Date of Birth: ______________

Your Current Health

Medical Conditions
Please List Any Current Medical Conditions you are being treated for

Medications
Please List All Current Medications you take, Including the Dose and Frequency

Medication Name	Dose	Frequency

Allergies
Please list any Specific Drug/Environmental/Food Allergies you may have and the type of reaction. If reaction unknown please indicate so

Allergy/Reaction: ______________________________
____

Care Team
Please list all providers you currently see

Name of Provider	Specialty/Location

Vaccines

Name of Vaccine	Date Received
Pneumovax	
Prevnar	
Shingrix (series of 2) or Zostavax (Shingles Vaccine)	
Flu Vaccine	
TDaP (Tetnaus Vaccine)	

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Screening Test(s)

Name of Test(s)	*Date Completed*	*Result (Normal/Abnormal)*
Colonoscopy		
Mammogram		
Pap Smear		
Bone Density		
Eye Exam		

Surgeries

Type of Surgery	*Date of Surgery*

Family History

Please fill out who has had the following medical conditions in your family- include Mother, Father, Siblings, Grandparents, Aunts, and Uncles, Children

Condition	*Family member*
High Blood Pressure	
Heart Attack	
Stroke	
Cancer (please specify which type)	
Diabetes	
Thyroid Disorder	
Depression	
Alcohol/Substance Abuse	
Glaucoma	
Any other serious illnesses	

Social History

✣ ***Marital Status (please circle):*** *Single* *Married* *Divorced* *Widowed* ✣***Number of Children:*** ________

✣***Employment (please circle):***
*Working/Occupation*________________ *Retired* *Disabled*

✣ ***Tobacco Usage (please circle):***

Never *Current Smoker* *Former Smoker*

Product Type: ________________ *How many/day?* ____________
Year Started Smoking: ____________ *Year Quit:* ____________

✣ ***Alcohol Usage (please circle):***

Never *Rarely* *Occasional* *Moderate*

How many alcoholic beverages do you consume days/week: ____________
Type of Alcohol (beer, wine, liquor): ____________

✣ ***Seatbelt Usage (please circle):*** *Always* *Sometimes* *Never*

✣***Exercise/Nutrition:***
*Days/week*____________ *Types of Exercise:* ____________

Do you eat a healthy/well balanced diet: *Yes* *No*

✣ ***Sun Exposure (please circle):***
Do you work regularly in the sun?: *Yes* *No* *Do you wear sunscreen:* *Always* *Sometimes* *Never*

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CREDIT CARD "SIGNATURE ON FILE" AUTHORIZATION FORM

CARY HEALTHCARE ASSOCIATES, PA offers a Credit Card on File program as a convenient method of paying for the portion of your services that are patient responsibility such as copay, deductible, and co-insurance expenses. Your credit card information will be kept confidential and secure.

I (we), the undersigned, authorize and request that CARY HEALTHCARE ASSOCIATES, PA charge my credit card for the balance due that my health plan has identified as my financial responsibility.
This authorization relates to all charges not covered by my insurance company for services provided to me by CARY HEALTHCARE ASSOCIATES, PA. My card will remain securely stored for future use by Payerpath, a secure credit card processor affiliated with Veradigm Payments Merchant's Services that partners with CARY HEALTHCARE ASSOCIATES, PA to collect payments. This authorization will remain in effect until revoked by me in writing.

PATIENT INFORMATION

Patient Name: ______________________________ DOB: __________

Street Address: ______________________________

City ______________________________ State: ______ Zip: __________

Home Phone: ______________________ Cell Phone: ______________________

Email: ______________________________

CARD INFORMATION

Credit Card Type: [ ] Visa [ ] Mastercard [ ] Discover [ ] American Express [ ] HSA / FSA

Name As It Appears on Card: ______________________________

Card Number: __________ - __________ - __________ - __________

Expiration Date: ______/______ CVV: __________

Printed Name: ______________________________

Patient/ Guardian Signature: ______________________________ Date: __________

CARY HEALTHCARE ASSOCIATE
301 ASHVILLE AVENUE, SUITE 111 ◊ CARY, NC
919-233-6000 TEL ◊ 919-233-60

Patient Name: ______________________

DOB: ______________________

PORTAL- FOLLOW MY HEALTH

As of 1/1/2025, Cary Healthcare Associates will be utilizing the patient portal for **ALL** patients to communicate the following:

- Lab results
- Patient messages
- Refill requests

This will be **mandatory** as implementing this system will allow patients to directly communicate with providers and staff more efficiently and decrease missed communications.

For Access:

1. CHA will send you a portal invite, which will be coming from "Follow my Health"
   a. Do **NOT** attempt to create an account without this initial invite
2. Once an invite is received via your email, it will prompt you to use a temporary password (which you will able to change once you sign in)

TEMPORARY PASSWORD: 0000

Please indicate below:

_____ I already have a portal and utilize it

_____ I do **NOT** have a portal and need invite sent to:

EMAIL: ______________________

CHA Use ONLY: Invite sent (date) ______ Initials______

Name:________________ DOB:________________

Name: ________________ DOB: ________________

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING __0__ + ______ + ______ + ______

=Total Score: ______

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Name: ________________

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Cary Healthcare Associates, PA

PRINT NAME : ______________________ DOB: ____________

Knowing more about what is going on in your life outside this office helps us work with you to achieve your best possible health. Please take a moment to complete this screening form.

HOUSING

- [ ] What is your housing situation today?
  - [ ] I do not have housing
  - [ ] I have housing today, but I am worried about losing housing in the future
  - [ ] I have housing

FOOD

- [ ] Within the past 12 months, you worried that your food would run out or did run out before you could buy more?
  - [ ] Often true
  - [ ] Sometimes true
  - [ ] Never true

UTILITIES

- [ ] In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?
  - [ ] Yes
  - [ ] No
  - [ ] Already shut off

PERSONAL SAFETY

- [ ] How often does anyone, including family, physically, sexually, or verbally hurt you?
  - [ ] Never
  - [ ] Rarely
  - [ ] Sometimes
  - [ ] Fairly often
  - [ ] Frequently

- [ ] How often does anyone, including family, threaten you with harm?
  - [ ] Never
  - [ ] Rarely
  - [ ] Sometimes
  - [ ] Fairly often
  - [ ] Frequently
- [ ] Do you feel safe at home?
  - [ ] Yes
  - [ ] No

ASSISTANCE

- [ ] Would you like any help with any of these needs?
  - [ ] Yes
  - [ ] No

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AUTHORIZATION TO RECEIVE MEDICAL INFORMATION

______________________________ ______________________________
Print Patient's Full Name Birth Date (Month/Day/Year)

____
Street Address

______________________________ ______________________________
City, State, Zip Code Phone (Daytime)

At the request of the individual, I ______________________________, do hereby authorize

____
Name of Company/Doctor's Office

____
Street Address City, State, Zip Code

____
Telephone Fax number

TO RELEASE THE FOLLOWING:

______Progress Notes ______Laboratory Reports ______Transferred Records
______Specialist Correspondence ______Radiology Reports
______Hospital Reports ______EKG
______Other

______I do ______I do not authorize the release of information related to AIDS or HIV, psychiatric and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO: **CARY HEALTHCARE ASSOCIATES, P.A.**
301 ASHVILLE AVENUE, SUITE 111, CARY, NC 27518
PHONE: (919)233-6000 FAX: (919) 233-6052

PURPOSE OF DISCLOSURE:

______Change of Doctor ______Insurance ______Legal Investigation
______ Referral to specialist ______Personal ______Workers Comp
______Other______________________________

This authorization shall be in force and effect until______________________________ at which time this authorization expires.

I understand I may cancel this request with written notification but it will not affect information released prior to notification of cancellation. I understand the information disclosed may be subjected to re-disclosure by the person or class of persons or facility receiving it would no longer be protected by federal regulations. I understand the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign this authorization.

______________________________ ______________________________
Signature of Individual or Guardian Date

NOTE: A processing fee may be charged. By law, maximum record copy fee is $ 0.75 per page for pages 1-25, $ 0.50 per pages 26-100 and $0.25 per pages over 100.

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Authorization to Leave a Message with Protected Health Information

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The HIPAA Privacy Rule permits Cary Healthcare Associates providers and staff to communicate with patients regarding their health care.This includes communicating with patients at their homes, whether through the mail, by phone, or via email. In addition, the Rule does not prohibit Cary Healthcare Associates providers and staff from leaving messages for patients on their answering machines. Messages that contain protected health information (PHI) require the patient to sign an authorization form to receive messages by voice mail. For example, messages that contain PHI would be test results, medication information, payment information, and treatment plans. The goal of this authorization is to decrease the call volume and delay in communication between patients, staff and providers.

However, to reasonably safeguard patient privacy, Cary Healthcare Associates providers and staff may limit the amount of information disclosed on the answering machine. This authorization is in effect until canceled in writing. I understand my HIPAA rights and I request that this office leave messages, including those containing PHI, for me by voicemail at the number noted below. I understand that it is my responsibility to keep the practice informed of any changes to this information. This authorization is in effect until canceled in writing.

Please check your preference below:

- ☐ Home Phone : ______________________
- ☐ Cell Phone : ______________________

______________________________ **Signature of Patient or Legal Guardian**

______________________________ **Relationship to Patient**

______________________________ **Print Patient's Name**

______________________________ **Print Legal Guardian's Name if applicable**

______________________________ **Date**