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, P.A.

PATIENT REGISTRATION FORMS

Compound Authorization for Release of Information

Rights of the Patient
Federal law says that we cannot share your health information without your permission except in certain situations. If you sign this form, you are giving permission to share your health information with the person you have indicated below.
This authorization is voluntary.
Right to revoke: If you decide you do not want us to share your health information any longer you must sign a revocation form.
The information 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.
Payment, enrollment or eligibility benefits of your healthcare will not be affected if you do not sign this authorization, unless the disclosure is for eligibility or enrollment determinations.

Print Name: _____ DOB: _____

I give permission to Cary Healthcare Associates, P.A. to share my health information with: (Write name and relation)

_____

_____

_____

May we leave a voicemail with information? Yes or No

Cary Healthcare Associates, P.A. may share my health information on this authorization form until this date of_____, or until I revoke the authorization in writing.

☐ All of my health care information ☐ Lab tests/ x-rays

☐ Information regarding prescription drug coverage

☐ Financial billing information

_____ Date:_____
Signature of Patient or Personal Representative
Description of Personal Representative's Authority (attach documentation)

Minor's Medical Treatment:

Child's Name: _____ Child's Date of Birth: _____
I being the parent or guardian of the above child, request and authorize any physician, nurse practitioner, or physician assistant at Cary Healthcare Associates and his/hers staff to perform all necessary medical care to my child, whether or not I am present at the appointment.

I authorize the following individuals to obtain medical care for this child, in my absence:

_____ _____
Name Relationship to Child

_____ _____
Name Relationship to Child

Signature of Parent or Guardian: _____ Date: _____

Cary Healthcare Associates, P.A.

Adult Health Questionnaire Form

Patient Name: _____ Date: _____

Date of birth: _____

Your Current Health

Please list your current medical conditions and medications you take on a regular basis.

Illness/Condition	Medications	Dose/Frequency

Drug Allergies: _____

Other Allergies: _____

Health Maintenance

Immunizations/Screening Tests:
When did you last have the following? Please include date.
Circle results for each test.

Tdap/Td vaccination_____
Pneumovax vaccination_____
Prevnar vaccination_____
Shingles vaccination_____
Gardasil/HPV vaccination_____
Hepatitis B vaccination_____
Flu vaccination_____

Colonoscopy_____ Normal or Abnormal
PSA_____ Normal or Abnormal
Eye Exam_____ Normal or Abnormal
Stress Test_____ Normal or Abnormal
Bone Density_____ Normal or Abnormal
Sleep Study_____ Normal or Abnormal
Mammogram_____ Normal or Abnormal
Pap Smear_____ Normal or Abnormal

Medical/Surgical History:

Please list all surgeries and dates if known:

_____

_____

Please list all hospitalizations and dates if known:

_____

_____

Please list all doctors that you currently see:

_____

_____

Cary Healthcare Associates, P.A.

Adult Health Questionnaire Form

Family History:

Who in your family has had: (ex: Father, Mother, Brother, Sister, etc.)

High Blood Pressure: _____
Heart Attack: _____
Stroke: _____
Cancer:(Please list what type) _____
Alcohol abuse: _____
Other serious illness in the family: _____

Diabetes: _____
Thyroid Disease: _____
Glaucoma: _____
Depression: _____

Social History:

Marital Status: (circle one) Single Married Widowed Divorced

Do you have children? Yes or No Number: _____

Employment status (circle one) Working Retired Disabled
Occupation: _____

Do you smoke? Yes or No
If no, did you ever smoke regularly and quit? Yes or No Year Quit: _____
If yes, how many cigarettes a day do you smoke? _____
When did you start smoking?
_____

Do you drink beer, wine, or liquor? Yes or No
If yes, how many drinks per day/week? _____

Do you have or had a problem with drug abuse? Yes or No

Do you always wear a seatbelt? Yes or No

How many times a week do you exercise? _____

Do you work regularly out in the sun? _____

Advance Directives:

Do you have a Living Will? Yes or No
Do you have a Power of Attorney for healthcare? Yes or No
If yes, Name/Phone #_____

Cary Healthcare Associates, P.A.

Pediatric Health Questionnaire Form

Patients Name: _____ Date: _____

Date of birth: _____

Your Current Health

Please list any current medical conditions and medications taken on a regular basis

Illness/Condition	Medications	Dose/Frequency

Drug Allergies: _____

Other Allergies: _____

Medical History

Please list any hospitalizations or surgeries and dates if known:

_____

Were there any significant complications during pregnancy or delivery for the child?

_____

Any recurrent illness, behavioral problems, or any problems/concerns we should be aware of and discuss?

_____

Family History:

Family Member	Name	DOB	Health Problems
Father			
Mother			
Sibling(s)			

Social History:

Does your child attend daycare or school? Yes No Is your child home schooled? Yes No

Does anyone in your home smoke? Yes No Do you have pets? Yes No What kind?

Do you have city water or well water? Yes No _____

Are you worried about your child's safety at home? Yes No

* Please bring child's current immunization record.

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
☐	☐	☐	☐

CARY HEALTHCARE ASSOCIATES, P.A.

NOTICE OF PRIVACY PRACTICES
For
PROTECTED HEALTH INFORMATION
(HIPAA)

222 Ashville Avenue
Suite 10
Cary, NC 27518

www.caryhealthcareassociates.com

Effective Date: 01/10/2016

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice, please contact our Privacy Officer at the number listed at the end of this Notice.

Each time you visit a healthcare provider, a record of your care is created. Typically, this record contains medical information such as your symptoms, examination, test results, diagnoses, treatment and/or treatment plan and billing-related information. This information is considered Protected Health Information (PHI).

This Notice is intended to advise you about the ways we may use and disclose medical information about you. It also describes your rights and certain obligations with regard to your medical information and applies to all of the records of your care generated by your healthcare provider(s) for our organization.

Our Responsibilities
Our Organization is required to maintain the privacy of your health information and to provide you with a description of our legal duties and Privacy Practices regarding your health information that we collect and maintain.

We are required by law to abide by the terms of this Notice and notify you if changes are made. We reserve the right to make changes to the Notice and make the new provisions effective for all protected health information we maintain.
Copies of our Notice are available in our main reception area(s) and on our website.

How We May Use and Disclose Medical Information About You.

The following describes examples of the way we may use and disclose medical information:

For Treatment: We may use medical information about you to provide, coordinate and manage your treatment or services. We may disclose medical information about you to other healthcare professionals such as physicians, nurses, technicians, clinical laboratories, imaging centers, medical students, or other personnel who are involved in your care.

We may communicate your information using various methods, orally, written, facsimile, and electronic communications. We may contact you to remind you of your appointment by telephone or reminder card unless requested otherwise.

For Payment: We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company, or a third party payer. Examples may include contacting your insurance company for referrals, verification, or preapproval of covered services.

For Health Care Operations: We may use or disclose, as needed, your health information in order to support our business activities. These activities may include, but are not limited to quality assessments, employee review activities, licensing, legal advice, accounting support, information systems support, and conducting or arranging for other business activities such as lab or radiology interfaces within the EHR. We may use or disclose, as needed, your health information within a medical group to support your care.

We may also provide other healthcare professionals who contribute to your care with copies of various reports and information to assist him/her and ensure that they have appropriate information regarding your condition/treatment plan and diagnosis.

Business Associates, BA: Provide services for our organization through written contracts and/or service agreements. Examples of these services include billing, collection, and software support. We may disclose your health information to a BA so they can perform the services we have asked them to do such as billing your third-party payer for services rendered. The BA is also required by law to protect and safeguard your health information which is clearly defined through our Business Associate Agreement and written contracts/service agreements.

Breach Notification: In the event that there has been a breach of unsecured protected health information (PHI) identified on behalf of our organization or a BA you will be notified within 60 days of the breach. In addition to your individual notification we may be required to meet further reporting requirements set forth by state and federal agencies.

Uses and Disclosures That May Be Made *With* Your Consent, Authorization or Opportunity to Object: We will not use and disclose information without your written authorization, except as described in this Notice or as required by applicable laws. Written authorization is required for, most uses and disclosures of psychotherapy notes; PHI for

marketing purposes unless we speak with you and disclosures that constitute a sale of PHI. If you provide an authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. However, we are unable to take back any disclosures we have already made with your authorization.

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may release medical information about you to a friend or family member who is involved in your medical care or who helps to pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Future Communications: We may communicate with you via newsletters, mailings or other means regarding treatment options and information on health-related benefits or services; to remind you that you have an appointment; or other community based initiatives or activities to include limited marketing or fundraising initiatives in which our facility is participating. You have the right to opt out at any time if you are not interested in receiving these communications, please contact our Privacy Officer.
Marketing and Fundraising initiatives, if applicable are limited and may require a separate authorization.

Uses and Disclosures That May Be Made *Without* Your Authorization or Opportunity to Object: We may use or disclose your health information in the following situations without your authorization or without providing you with an opportunity to object. These situations include:

As required by law: We may use and disclose health information to the following types of entities, including but not limited to:
☐ Food and Drug Administration
☐ Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
☐ Correctional Institutions
☐ Workers Compensation Agents
☐ Organ and Tissue Donation Organizations
☐ Military Command Authorities
☐ Health Oversight Agencies
☐ Funeral Directors, Coroners and Medical Directors
☐ National Security and Intelligence Agencies
☐ Protective Services for the President and Others
☐ Authority that receives reports on abuse and neglect

If you are not present, able to agree or object to the use or disclosure (such as in an emergency situation), then your healthcare provider may, using professional judgment will determine whether the disclosure is in your best interest. In this case, only the information that is relevant to your health care will be disclosed.

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena or court order.

State-Specific Requirements: Many states have reporting requirements which may include population-based activities relating to improving health or reducing health care costs, cancer registries, birth defect registries and others.

Your Health Information Rights
Although your health record is the physical property of the practice that compiled it, you have the right to:

Inspect and Copy: You and/or your personal representative have the right to inspect, review and receive a copy of your medical information. Electronic copies are available and may include various electronic means such as a patient portal or other reasonable accommodations requested. We may deny your request to inspect and copy in limited circumstances to include release of psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. If you are denied access to medical information, you may request that the denial be reviewed.

Requests to copy and/or a review must be submitted in writing to our practice. There will be a fee charged for all applicable copying and producing copy of portable media (CD, USB) up to the maximum amount as prescribed by governing law.

Amend: If you feel that the medical information we have is incomplete or incorrect, you may ask us to amend the information by submitting a request in writing.
We may not agree or be required to agree to your request(s) for specific reasons, if this occurs, you will be informed of the reason(s) for the denial.

An Accounting of Disclosures: You have the right to request an accounting of our disclosures of your medical information; the list will not include disclosures to carry out treatment, payment and healthcare operations. OUR PRACTICE will provide the first accounting to you in any 12-month period without charge, upon receipt of your written request. The cost for subsequent requests for an accounting within the 12-month period will be up to the maximum amount prescribed by governing law.

Request Restrictions: You have the right to request a restriction or limitation of your medical information we use or disclose about you for treatment, payment or health care operations.
Restrictions from your health plan (insurance company): You have the right to request that we restrict disclosure of your medical information to your health plan for covered services, provided the disclosure is not required by other laws. Services must be paid in full by you, out of pocket.

Other Restrictions, Limiting Information: You also have the right to request and limit any medical information we disclose about you to someone who may be involved in your care or the payment of your care, such as a family member or friend. We ask that you submit these requests in writing.
We may not agree or be required to agree to your request(s) for specific reasons, if this occurs, you will be informed of the reason(s) for the denial.

Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will agree to the request to the extent that it is reasonable for us to do so. For example,

you may request that we use an alternate phone number or address. We ask that you submit these requests in writing.

To exercise any of your rights, please submit your request in writing to the practice's privacy officer indicated below.

For More Information or to Report a Problem
If you have questions and would like additional information please contact the Privacy Officer. If you believe that your (or someone else's) privacy rights may have been violated, you may file a complaint with the Privacy Officer at the contact number below or with the Secretary of Health and Human Services. All complaints must be submitted in writing within 180 days of when you knew that the act or omission occurred and there will be no retaliation for filing a complaint.

Privacy Officer
222 Ashville Avenue
Cary, NC 27518
Phone:(919)233-6000

CARY HEALTHCARE ASSOCIATES, P.A.
222 Ashville Avenue, Suite10
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, P.A.

OFFICE POLICIES

FINANCIAL AGREEMENTS

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES INCURRED AT CARY HEALTHCARE ASSOCIATES. IF YOUR INSURANCE REQUIRES THAT YOU PAY A CO-PAY, DEDUCTIBLE, OR CO-INSURANCE YOU ARE RESPONSIBLE FOR FULL PAYMENT AT TIME OF THE SERVICE.

IF YOU HAVE NO INSURANCE YOU WILL BE REQUIRED TO PAY IN FULL AT TIME OF SERVICE.

I UNDERSTAND THAT I AM RESPONSIBLE FOR CHARGES INCURRED AT CARY HEALTHCARE ASSOCIATES REGARDLESS OF THIRD PARTY LIABILITY. (INSURANCE CARRIER)

CANCELLATION POLICY

I UNDERSTAND THAT A 24 HOURS NOTICE IS REQUIRED TO CANCEL APPOINTMENTS. PLEASE BE NOTIFIED THAT 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: _____