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, 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: ____________

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.

CARY HEALTHCARE ASSOCIATES, PA

301 ASHVILLE AVENUE, SUITE 111 ◊ CARY, NC 27518

919-233-6000 TEL ◊ 919-233-6052 FAX

Medical Authorization Form
(Consent to Treat a Minor, aged 16-18)

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR, AGED 16-18, WHEN UNACCOMPANIED BY PARENT/LEGAL GUARDIAN

I, ________________________________, parent or legal guardian of __________________________________, a minor (aged 16-18), do hereby authorize and consent that he/she may be seen, evaluated and treated by any Medical Doctor, Family Nurse Practitioner, Physician Assistant, Medical Assistant or Nurse at Cary Healthcare Associates.

I understand that any medical treatment provided to _________________________ will be disclosed to me as the parent/legal guardian upon my request.

Limitations: In the box below please identify any limitations of medical services you, as the parent/legal guardian, do NOT consent the above patient to receive without your verbal consent at the time of the visit (Example: Immunizations, office procedures, exams, labs etc.)

I may revoke this authorization at any time in writing by completing the revocation form which can be provided by Cary Healthcare Associates, PA at my request*

______________________________ (Printed name of Patient/Date of Birth)	______________________________ (Parent/Legal Guardian Phone number)
______________________________ (Parent/Legal Guardian Signature)	______________________________ (Parent/Legal Guardian Printed Name)
______________________________ (Witness)	______________________________ (Date)

CARY HEALTHCARE ASSOCIATES, PA
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Medical Authorization Form (Consent to Treat a Minor)

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR WHEN PATIENT IS ACCOMPANIED BY AN ADULT OTHER THAN PARENT/LEGAL GUARDIAN

I, ______________________________, parent or legal guardian of ______________________________, a minor, do hereby authorize the following name(s); (example: friend, grandparent, aunt, uncle, neighbor, step parent etc.)

Name	Relationship to patient	Phone number

As my agent(s), I give the above listed permission to consent to any medical evaluation and/or treatment, physical examination, advised immunizations/injections, in office procedures/surgical treatment(s), referrals, diagnosis or care which is deemed advisable by and is to be rendered under, the general or special supervision of a licensed physician, which includes: Medical Doctors (MD), Nurse Practitioners or Physician Assistant.
This authorization includes hospital admission if such is deemed necessary by the physician.
It is understood that this authorization is given to provide authority and power on the part of my absence for the above agent(s) to give specific consent to any and all such evaluation(s)/treatment(s).
This authorization also grants to my agent(s) the power to sign for release of information to any third party payers who may be responsible for part or all of the cost of the services provided.

Limitations: In the box below please identify any limitations of medical services you, as the parent/legal guardian, do **NOT** consent the above agent(s) to authorize

I may revoke this authorization at any time <u>in writing</u> by completing the revocation form which can be provided by Cary Healthcare Associates, PA at my request*

______________________________ (Parent/Legal Guardian Signature)

______________________________ (Printed name of Parent/Legal Guardian)

______________________________ (Witness)

______________________________ (Date)