1309 LEES CHAPEL ROAD
GREENSBORO, NC 27455
Phone: (336) 286 -5505 Fax: (336) 286-5583

Today's Date:_____ Patient Account:_____

Last Name:_____ First Name:_____ MI:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Home: ( )_____-_____ Mobile: ( )_____-_____ Email:_____

SSN#:_____-_____-_____ Sex: ( ) Male ( ) Female Age:_____

D.O.B: _____/_____/_____ Marital Status:_____

Race:_____ Ethnicity:__ Hispanic __ Non-Hispanic __ All Other:_____

Employer/School:_____ Occupation:_____

Primary Care Provider (Family Doctor):_____

IN CASE OF EMERGENCY, WHO SHOULD WE CONTACT? Name, Address, Phone/Cell

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PRIMARY INSURANCE INFORMATION

Subscriber's Name: _____

Relationship to Patient:_____ **D.O.B**:_____/_____/_____

Reason for visit:_____

Current Medications:_____

_____

Pharmacy Preference: _____

~~~~~~~~~~~~~~~~~~ **FOR OFFICE USE ONLY** ~~~~~~~~~~~~~~~~~~~~~~~~

New/Est Copay:_____ Cash/Check/Charge Self Pay/UC/FP INS _____

Verification _____ Check In:_____ Room Time:_____
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Health Screening

We believe everyone should have the opportunity for health. Some things like not having enough food or reliable transportation or a safe place to live can make it hard to be healthy. Please answer the following questions to help us better understand you and your current situation. We may not be able to find resources for all of your needs, but we will try and help as much as we can.

	Yes	No
1. Within the past 12 months, did you worry that your food would run out before you got money to buy more?		
2. Within the past 12 months, did the food you brought just not last and you didn't have money to get more?		
3. Within the past 12 months, have you ever stayed: outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home (i.e couch-surfing)?		
4. Are you worried about losing your housing?		
5. Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed?		
6. Within the past 12 months, has lack of transportation kept you from medical appointments or from doing things needed for daily living?		
7. Do you feel physically or emotionally unsafe where you live currently?		
8. Within the past 12 months, have you been hi, slapped, kicked or otherwise physically hurt by anyone?		
9. Within the past 12 months, have you been humiliated or emotionally abused by anyone?		
10. Are any of your needs urgent? For example, you don't have food tonight, you don't have a place to sleep tonight, you are afraid you will get hurt if you go home today.		
11. Would you like help with any of these that you have identified?		

Triad
PRIMARY CARE

Patient Account :_____

Today's Date: _____

Last Name: _____ First Name :_____ MI: ____ DOB:_____

Reason for Visit:_____

Pharmacy Preference:_____

Vitals:

Weight: _____ Height: _____

Temp: _____ Pulse: _____ BP: ____/____

O2% :_____ Resp: _____ LMP: _____

Allergies: _____

PROVIDER'S NOTES:

IN HOUSE ORDERS:

UA Pregnancy _____

Glucose _____

HBGA1C _____

FLU A/B _____

KOH _____

Lipid Panel _____

Monospot _____

Rapid Strep _____

UA w/o Micro _____

UA w/ Micro _____

Wet Prep _____

TB (PPD) _____

5 Panel Rapid Drug Screen _____

12 Panel Rapid Drug Screen _____

Medications: _____

XRAYS: _____

SEND OUT LABS: _____

Work Note: _____

***** FOR OFFICE USE ONLY*****

COPAYS: _____ Cash/Check/ Charge SELF PAY/ UC/FP Insurance Carrier: _____

Verification: _____ Check In: _____ Room Time:_____

DESIGNATED PARTY RELEASE FORM

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home: _____ Cell: _____ Work: _____

If we are unable to contact you by phone regarding your labs, xrays ect…..may we leave a message on your answering machine/ voicemail on the above listed numbers? Please check below

( ) Yes or ( ) No

Please list below the appropriate individuals with whom we may leave medical information regarding your health.

Name : _____ Phone : _____

Relationship to Patient : _____

Name: _____ Phone: _____

Relationship to Patient: _____

Primary Care Provider (Doctor) to release information to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

_____ _____

Signature Date

FINANCIAL POLICY

Welcome to Triad Primary Care. Thank you for choosing our facility to provide you with your healthcare needs. If you currently use or would like to use our office as your Primary Care Provider, we will file as Primary Care otherwise we will file your claim as an Urgent Care visit. We would like to make sure you are aware that there are different Co-Pays and your insurance will process your claims accordingly and any Explanation of Benefits or Patient Billing you receive will reflect as such.

1. ***Insurance***- We participate with most major insurances. For a complete list, please refer to the signage posted at check-in. Knowing your insurance benefits is your responsibility. All patients must complete our patient information packet prior to receiving treatment. **We must obtain a copy of your driver's license or valid id and current insurance card to provide medical services.** If you are unable to provide us with a current copy of your insurance card, payment for services is expected at time of service. If your insurance coverage changes, please notify us before the 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 could be billed to you.** It is the patient's responsibility to provide us with the most current insurance information and bring their card to each visit.

2. ***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 your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance; we are not a part of that contract. **We will collect credit card information to be kept on file and will run that card for an amount of no greater than $50.00 for any balance not covered by your insurance company.**

3. ***Referrals-*** It is the patient's responsibility to ensure any required referrals for treatments are provided to the practice before the visit, visits may be rescheduled, or the patient may be responsible due to lack of the referral.

4. ***Self-Pay/Payment***- Patients that do not have insurance are expected to pay for medical services at the time services are rendered. If the visit exceeds a balance of $300 after payment for the office visit, we will retain a copy of your credit card information on file and run the balance in 30 days from dates of service.

5. ***Forms***- If you have disability, FMLA papers ect, we will be more than happy to assist you in filling them out. Our facility charges a $15form fee that must be paid prior to form completion. Medical record fees are set at $10 up to 20 pages, thereafter .50 per page is charged.

6. ***Collections***- Once your account goes beyond 90 days, it is subject to collection action. **If your account is turned over to collections you will not be able to receive medical care including prescription refills until balance in full has been paid**. Payment arrangements cannot be made once the account has been turned over. Patients who are having financial difficulties should contact our billing department at **336-286-5505** to work out a satisfactory payment plan.

7. ***Return Checks***- A fee of $30 will be assessed on any return checks.

Please sign in the space provided below acknowledging you have read and understand the Financial Policy.
Again thank you for choosing Traid Primary Care. We look forward to servicing your healthcare need todays and in the future.

_____ _____

Patient/ Guardian Signature Date