



ALLIANCE INTERNAL MEDICINE, PLLC

"WORKING TOGETHER TOWARDS BETTER HEALTH"

2215 Canterwood Drive
Wilmington, NC 28401
phone: 910-762-4600
fax: 910-762-9483

Patient Registration Form

Name _____
Last First Middle

Address: _____

Home #: _____ Cell #: _____ Work #: _____
City State Zip

Date of Birth: _____

Please Check: Sex: Male Female
Marital Status: Single Married Divorced Widowed

Social Security #: _____ Employer/School: _____

Employer Address: _____ Employer #: _____

Emergency Contact: _____ Relation: _____ Phone #: _____

Insurance Information (Please present Insurance Card at time of Check-In)

| Insurance Information | Primary | Secondary |
|---------------------------------|---------|-----------|
| Name of Insurance Company | | |
| Insurance ID # | | |
| Group ID # | | |
| Name of Policyholder/Subscriber | | |
| DOB of Policyholder/Subscriber | | |
| SSN of Policyholder/Subscriber | | |

Email: _____ Would you like Patient Portal? Yes No

Ok to Leave a Message at: Home and/or Cell
 Brief Brief
 Extended Extended

Pharmacy: _____ Address: _____ Phone #: _____

Signature: _____ Date: _____

PERSONAL MEDICAL HISTORY

Do you currently have or have you ever been diagnosed with the following problems?

| | | | | | |
|----------------------|-------|-----|------------------|-------|-----|
| Diabetes: | No | Yes | Osteoarthritis: | No | Yes |
| COPD: | No | Yes | Frequent UTI: | No | Yes |
| High Blood Pressure: | No | Yes | Ehlers-Danlos: | No | Yes |
| Heart Problem: | No | Yes | Asthma: | No | Yes |
| Frequent Infections: | No | Yes | | No | Yes |
| Anxiety: | No | Yes | | | |
| Depression: | No | Yes | | | |
| Kidney Stones: | No | Yes | | | |
| Cancer: | No | Yes | If yes, specify: | _____ | |
| Thyroid Disorder: | No | Yes | If yes, specify: | _____ | |
| Other: | _____ | | | | |

Surgeries: Date: _____ Type of Surgery: _____

Please Circle and Fill in the Blank for Blood Relatives:

Father: Living / Deceased Cause of Death: _____

Mother: Living / Deceased Cause of Death: _____

Brother(s): # ___ Living # ___ Deceased Cause of Death: _____

Sister(s): # ___ Living # ___ Deceased Cause of Death: _____

FAMILY MEDICAL HISTORY:

If any of your blood relatives have ever been diagnosed with the following, please circle Yes and specify who and what type. (Please specify maternal/paternal)

| | | | | |
|----------------------|----|-----|-----------|-------|
| Diabetes: | No | Yes | Who: | _____ |
| Cancer: | No | Yes | Who/Type: | _____ |
| Tumor/Lesion: | No | Yes | Type: | _____ |
| Stroke: | No | Yes | Who: | _____ |
| Heart Problem: | No | Yes | Who/Type: | _____ |
| High Blood Pressure: | No | Yes | Who: | _____ |
| Autoimmune Disease: | No | Yes | Who/Type: | _____ |
| Thyroid Disease: | No | Yes | Who/Type: | _____ |
| Thyroid Cancer: | No | Yes | Who/Type: | _____ |
| Other Problems: | No | Yes | Specify: | _____ |

Patient Name: _____

Date of Birth: _____



Consent for Purposes of Treatment, Payment, and Healthcare Operations

I consent to the use or disclosure of my protected health information by Alliance Internal Medicine for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Alliance Internal Medicine.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Alliance Internal Medicine is not required to agree to the restrictions that I may request, the restriction is binding on Alliance Internal Medicine.

I have the right to revoke this consent, in writing, at any time, except Alliance Internal Medicine has taken action in reliance on this consent.

My “protected health information” means health information, including my demographic information, collected from me, and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information related to my past, present, or future physical or mental health or condition identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Alliance Internal Medicine’s Notice of Privacy Practices prior to signing this document. Alliance Internal Medicine Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Alliance Internal Medicine. The Notice of Privacy Practices for them is also provided in the waiting area. This Notice of Privacy Practices also describes my rights and Alliance Internal Medicine’s duties with respect to my protected health information.

Alliance Internal Medicine reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

_____ Description of Personal Representative’s Authority



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Insurance Policy

Welcome to our practice. We are committed to providing you with the best possible care and we are open to discussing our professional fees with you at any time.

Currently, we are participating with most major insurance companies. However, all deductibles, co-payments, and/or co-insurance payments are due at time of service. If your insurance has a percentage co-insurance, please be prepared to make this payment at the time of service.

In order for insurance claims to be filed promptly it is your responsibility to inform our office of any changes to your insurance. If you do not provide correct insurance information to the office, this may result in claims being denied for timely filing. If a claim is denied for timely filing for this reason, you will be responsible for all charges.

Financial Policy

Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions.

As per above payment is due at time of service. We accept cash, checks, Visa, MasterCard, and Discover.

Returned checks will be subject to additional collection fees.

Self-Pay patients must pay entire discounted amount on the date of service. Patients with past due balances must pay entire balance plus today's charges.

We realize that temporary financial problems may affect timely payments of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. Payment arrangements must be made prior to treatment.

Thank you for understanding our financial and insurance policies. If you have any questions about the above information, do not hesitate to ask us. We are here to assist you.

Signature: _____ Date: _____

Upon request a copy of this agreement will be given to the patient.



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EPRESCRIBING CONSENT FORM

ePrescribing is defined by a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an ePrescribe program.

These include:

- **Formulary and benefit transactions**
Gives the prescriber information about which drugs are covered by the drug benefit plan
- **Medication history transactions**
Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification**
Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Alliance Internal Medicine can request and use your prescription medication history from other healthcare providers and /or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Alliance Internal Medicine to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Patient Name

Date of Birth

Signature of Patient or Representative

Date



Appointment Cancellation Policy

At Alliance Internal Medicine we strive to render excellent medical care to you and the rest of our patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

We request that you please give our office 24- hour notice in the event that you need to reschedule your appointment. This allows other patients to be scheduled into that appointment. It also makes it possible to reschedule your appointment more efficiently.

Additionally, if a patient is more than 15 minutes late to his/her appointment, the appointment may be cancelled.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

Patient Signature

Date

Printed Name of Patient

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

This form is for use when such authorization is required and complies with the HIPPA Privacy Rule (45 CFR §164.500-534).

Patient: _____

Date of Birth: _____

Address: _____

Telephone: _____

| | |
|---|---|
| <p>Release Information From:</p> <p>_____</p> <p>(List applicable Facility(s) and/or Practice(s))</p> <p>_____</p> <p>_____</p> <p>(Phone number) _____ (Fax number) _____</p> | <p>Release Information To:</p> <p>_____</p> <p>(Name of Facility, person, company)</p> <p>_____</p> <p>(Street Address or PO Box, City, State, Zip Code)</p> <p>_____</p> <p>(Phone number) _____ (Fax number) _____</p> |
|---|---|

Treatment dates: From: _____ **To:** _____

PURPOSE OF RELEASE (check reason): Request of individual/personal Continued patient care

Insurance Legal purpose including discussions & proceedings Other _____

- | | | |
|--|--|---|
| <input type="checkbox"/> Complete Medical Record | <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Laboratory Reports |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Operative/Pathology Reports | <input type="checkbox"/> Cardiology Reports |
| <input type="checkbox"/> Emergency Room Report | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Physical Therapy Reports |
| <input type="checkbox"/> History & Physical Exam | <input type="checkbox"/> Radiology Reports | |

Other (please specify): _____

Delivery method: Fax E-mail Paper Copy via USPS CD/DVD Other:

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or 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.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority

Witness



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New Patient Consent Form

I further understand that Alliance Internal Medicine, PLLC reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164-520 of the code of Federal Regulations. Should Alliance Internal Medicine, PLLC change their notice, they will send a copy of any revised notice to the address I have provided (whether US mail or, if I agree, email).

I give my permission for the following person(s) to have access to my medical records:

I give my permission for messages to be left at the following numbers regarding appointment dates and times, test results and healthcare concerns:

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept/decline the term of this consent.

Patient's Signature

Date