Notifier(s): MEDCENTER 1 (TERESA A. SMITH MD)

Patient Name: ______________________________

Patient Identifier: ___________________________

Insurance ID: _______________________________

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If your insurance carrier, ________________________, doesn't pay for any of the items listed below, you may have to pay. Commercial insurance does not pay for everything, even if you or your health care provider has good reason to think you need the service or services.
We expect your carrier may not pay for the items listed:

Listed Items	Estimated Cost
EKG	$55.00
ABI (Ankle Brachial Index)	$175.00
Diabetic Foot Exam	$150.00
Orthopedic supplies	Varies by Orthotic needed
Ice Pack	$10.00
Laboratory Services	Varies by Lab needed

What you need to do now:
- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option 1, 2 or 3 as a courtesy we may help you to use any other insurance that you might have, but your carrier cannot require us to do this.

Options: Check only one box. We cannot choose a box for you.

____ **OPTION 1.** I want the test listed above. You may ask to be paid now, but I also want my carrier billed for an official decision on payment, which is sent to me on an Explanation of Benefits (EOB). I understand that if my insurance doesn't pay, I am responsible for payment, but I can appeal to my carrier by following the directions on the EOB. If my carrier does pay, you will refund any payments I made to you, less co-pays or deductibles.

____ **OPTION 2.** I want the test listed above, but do not bill my insurance. You may ask to be paid for services now as I am responsible for payment. I cannot appeal if my carrier is not billed.

____ **OPTION 3.** I don't want the test listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if my carrier would pay.

This notice gives our opinion, not an official Carrier decision. If you have other questions on this notice or billing, call your carrier at the number listed on the back of your ID card. By signing below means that you have received and understand this notice.

______________________________ ______________________

Patient Signature Date

Med Center 1
1688 East Arlington Blvd.
Greenville, NC 27858
(252) 353-1464

Name: ______________________________ Phone# ____________________
Last First MI

Street Address: ____

Mailing Address ____

City ________________ St _____ Zip: _________-________ Sex: (circle one) M/F

Birth date: _________ SS# ________________ Drivers License # ____________

Email: ____

Marital Status (circle one) S M SEP DIV WID
Employment Status (circle one) F/T P/T Retired Unemployed Self Employed
Student Status (circle one) F/T P/T Non

Patient Employer ___________________________ Phone# _______________

Spouse's Name ________________ Spouse's DOB ______________________

Spouse SS# ___________________ Spouse's Phone# ____________________

Ins Plan Name ____

Policy Holder
Name _______________________ DOB ________ SS#_______________

Emergency contact name and number _________________________________

I, the Patient, Parent or Guardian of a minor under 18, certify that the insurance information is correct. I hereby authorize Med Center 1 to release all necessary information to secure payment of benefits. I authorize the use of my signature on all insurance submissions. I am also aware that I am responsible for all charges not covered by my insurance.
We do not accept Medicare assignment therefore you are responsible for your charges. As a courtesy we will file your charges to Medicare so reimbursement will go to you.

Method of payment (circle) Cash Credit Card Check Insurance Employer

Signature: _____________________________ Date: ______________

Med Center 1
1688 E. Arlington Blvd
Greenville, NC 27858
252-353-1464 Phone
252-353-1272 Fax

Patient Acknowledgement
Receipt of Privacy Notice

I, ________________________________ hereby affirm that I have received a copy of the *Notice of Privacy Practices* from Med Center 1. Under federal law 104-191, also known as HIPAA, I am entitled to receive a copy of this *Notice* from my healthcare provider.

I understand that my signature on this Acknowledgement only signifies that I have received a copy of the *Notice*, and does not legally bind or obligate me in any way.

I understand that I am entitled to receive a copy of the *Notice of Privacy Practices* from my healthcare provider, whether I sign this Acknowledgement or not.

Patient Name: ______________________________________

Signature of Patient or Personal Representative: ______________________________________

Name of Patient or Personal Representative: ______________________________________

Date: _______________

____

Description of Personal Representative's Authority (if applicable)

FOR OFFICE USE ONLY **Received by:**	
Date Received:	Time Received:
Patient Declined ☐	
Staff Signature:	

HEALTH HISTORY
(Confidential)

Name:____ Today's Date________________

Age:_____________ Date of Birth:______________________ Date of last physical:__________________

SYMPTOMS: Check (✓) any symptoms you currently have or have had in the past year

GENERAL
- ☐ Anxiety
- ☐ Chills
- ☐ Cough
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Mood changes
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
pain, weakness, numbness in:

☐arms	☐back
☐feet	☐hands
☐hips	☐legs
☐neck	☐shoulders

GENITOURINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful Urination

GASTROINTESTINAL
- ☐ Poor appetite
- ☐ Bloating
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOPULMONARY
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Shortness of breath
- ☐ Swollen ankles
- ☐ Wheezing
- ☐ Varicose veins

EYE,EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Ear ache
- ☐ Ear drainage
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Seasonal allergies
- ☐ Sinus problems
- ☐ Vision—flashes
- ☐ Vision—halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sores that won't heal

MEN ONLY
- ☐ Erection difficulty
- ☐ Lump in chest
- ☐ Lump in testicles
- ☐ Discharge from penis
- ☐ Sore on penis
- ☐ Other:_____________

WOMEN ONLY
- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Heavy periods
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other:______________

Last period:_____________

Are you pregnant:________

Current birth control method:______________

Are you trying to become pregnant?__________

MEDICAL CONDITIONS: Check (✓) conditions you have or have had in the past

☐ AIDS	☐ Depression	☐ HIV Positive	☐ Psychiatric Care
☐ Alcoholism	☐ Diabetes	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anemia	☐ Emphysema	☐ Liver Disease	☐ Scarlet Fever
☐ Anorexia	☐ Epilepsy	☐ Lupus	☐ Seasonal Allergies
☐ Appendicitis	☐ Fibromyalgia	☐ Measles	☐ STD
☐ Arthritis	☐ Glaucoma	☐ Migraine Headaches	☐ Stroke
☐ Asthma	☐ Goiter	☐ Miscarriage	☐ Suicide Attempt
☐ Breast Lump	☐ Gonorrhea	☐ Mononucleosis	☐ Thyroid Problem
☐ Bronchitis	☐ Gout	☐ Multiple Sclerosis	☐ Tonsillitis
☐ Bulimia	☐ Heart Disease	☐ Mumps	☐ Tuberculosis
☐ Cancer	☐ Hepatitis	☐ Pacemaker	☐ Typhoid Fever
☐ Cataracts	☐ Hernia	☐ Pneumonia	☐ Ulcers
☐ Chemical Dependency	☐ Herpes	☐ Polio	☐ Uterine Fibroids
☐ Chicken Pox	☐ High Cholesterol	☐ Prostate Problem	☐ Vaginal Infections

MEDICATIONS List medications you are currently taking	**ALLERGIES** to medicines
Pharmacy name_____________________ Phone __________	

(this information is also strictly confidential)

FAMILY HISTORY Please fill in health information about your family

Relation	Age	Health (good, fair, poor)	Age of Death	Cause of Death	Check (✓) if a blood relative had any of the following: Disease	Relationship to You
Father						
Mother						
Brothers						
Sisters						

	Disease	Relationship to You
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer (please note type)	
	Chemical dependency	
	COPD/emphysema	
	Diabetes	
	Heart Attack or Surgery	
	High Blood Pressure	
	Kidney Disease/Stones	
	Stroke	
	Tuberculosis	
	Other	

HOSPITALIZATIONS AND SURGERIES

Year	Hospital	Reason and Outcome

PREGNANCY HISTORY

Year	sex of child	complications

Have you ever had a blood transfusion? ☐ Yes ☐ No
If YES, when _____ If YES, have you had a Hepatitis test? ☐ Yes ☐ No

OTHER ILLNESSES/INJURIES	DATE	OUTCOME

SCREENING EXAMINATIONS Please list the date of your most recent exam

Examination	Date	Results
Bone Density Test		
Colonoscopy		
Mammogram		
Pap Smear		
Prostate check		

HEALTH HABITS Check (✓) which substances you use

	Substance	How much do you use?
	Caffeine	
	Tobacco	___packs per day for ___ years
	Alcohol	___ daily ___weekly ___other
	Drugs	
	Other	

OCCUPATIONAL CONCERNS
Are you exposed to:

	Stress
	Hazardous Substances
	Heavy Lifting
	Outdoor environment
	Other

What kind of work do you do?

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

______________________________ Patient/Guardian Signature   ______________ Date

______________________________ Reviewed by: Triage/Provider Signature   ______________ Date

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

MEDCENTER 1
1688 East Arlington Boulevard
Greenville, North Carolina 27858
Phone (252) 353-1464
Fax (252)353-1272

Date: ______________________________

Patient Name: ______________________________

Address: ______________________________

____

Date of Birth: ______________________________

Social Security # : ______________________________

I authorize ________________________ to release to ________________________ my medical records as designated by my initials below. I consent to have my records, including any labs faxed to the aforestated. Please initial all applicable below:

- ________ Office notes
- ________ All specialist notes (if applicable)
- ________ Diagnostic tests (including the faxing of my labs/x-rays/special diagnostic scans)
- ________ HIV results
- ________ Psychiatric information
- ________ Substance abuse information

I do not have to sign this authorization in order to receive treatment from Med Center 1. In fact, I have the right to refuse to sign this authorization. I also have the right to inspect or copy the information to be used or disclosed. When my information is used or disclosed pursuant to this authorization it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization.

Purpose of disclosure ______________________________

Expiration Date ______________________________

Patient Sign : ______________________________

Witness: ______________________________