Carolinas HealthCare System

Welcome *to Bessemer City Family Medicine . . .*

www.carolinashealthcare.org/bessemer-city-family-medicine
3326 Bessemer City Road
Bessemer City, NC 28016
(704) 629-0412

Introduction

Thank you for selecting us as the Primary Care Providers for you and your family. ***Bessemer City Family Medicine*** was founded in 2007 and its mission is to provide **outstanding** medical care for all of our patients. We will provide you and your family with high quality care through superior customer service.

Services

Our staff includes a board certified physician, David Cosenza, MD and a board certified Physician Assistant, Savanna Hancock, PA-C; nursing and clerical personnel, and a practice manager.

All efforts will be made to schedule your appointments with your Continuity Provider. There may be times in which your Continuity Provider may be unavailable and we will schedule you with their Partner Provider within the Practice to ensure timely service for our patients.

We provide comprehensive, high quality care to children and adults from birth through their entire adult life. We offer same day sick examinations, well child examinations, school and sports physicals, adult physical exams, breathing treatments, immunization/allergy vaccinations, laboratory services, and minor procedures such as suturing, EKG, pulmonary function testing, etc.

The providers also refer patients to the admitting physicians at Cleveland Regional Medical Center and/or Kings Mountain Hospital for inpatient care and hospital procedures. This specialized group of physicians is qualified to treat you and your family in the hospital setting, as well as consult with other specialists in order to render the best care available to you.

Prescriptions

Please notify your pharmacy in regards to prescription refills and they will fax a request to our office. The providers may also call in certain prescriptions and these requests are taken **only** during regular business days until 4 PM. We require a **full business-day notice** for these medications, as the provider needs time to review the medical record.

Prescriptions, such as medicines for Attention Deficit Disorder (ADD), cannot be phoned into a pharmacy. **The Providers do not prescribe Controlled Substances (Narcotics) for Chronic Pain or Chronic Anxiety Management**. If you are a new patient, the providers **will not** prescribe certain medications until they have reviewed your medical record from your previous physician. You will be asked to follow up with a Pain Specialist for Chronic Pain Treatment or a Psychiatrist for Chronic Anxiety Treatment.

Chronic illnesses require periodic visits. Refills will be denied if scheduled visits are not kept.

No Shows and Cancellations

Situations may arise when you cannot keep your medical appointment and we fully understand. However, we require at least **24 hours** advanced notice, unless it is an emergency. Repeated no shows or cancellations may result in dismissal from the clinic for the patient.

Referrals

In some cases our Providers may need to refer you to a specialist. In these instances our Nurse will set up the appointment before you leave the office with the **exception** of some referrals that may take longer due to the policies of the office where we are referring you to be seen. In this case we will notify you once the appointment is available.

Hours of Operation

You can reach us at **(704) 629-0412**. The providers will respond to your calls and questions as quickly as possible, as they need time to review your medical record and the information given by you to our staff.

Our office hours are from 8:15 AM to 5:00 PM Monday through Friday. To reach us after hours or on weekends, we use an answering service. These highly trained nurses can address a variety of your concerns. Complicated or serious medical conditions are discussed with the on-call physician for final disposition. The providers are on call 24 hours a day, 7 days a week.

Sick and physical exam visits are made by appointment **only.** Any walk-in patients will be given the next available appointment, depending on the severity of the illness/injury. Patients arriving late for appointments may have to reschedule, depending on the patient volume for the day.

Allergy shots are given by appointment on Monday - Friday from 8:30 AM to 11:00 AM and from 2:00 PM until 4:30 PM. Patients must remain in the clinic for 30 minutes **after** the injection is given.

The official holidays for the clinic are Good Friday, Memorial Day, July Fourth, Labor Day, Thanksgiving Day, Christmas Day, and New Year's Day. We will post any holiday changes in advance. **For closings due to bad weather,** please call the clinic or check the local TV stations of WSOC TV 9 (ABC) and WCNC-TV (NBC).

Forms, Medical Records, and Results

Medical Records will be issued within 10 business days upon a signed medical release from the patient.

Results for laboratory, x-rays, or other studies are usually available 5-7 business days after the test was performed.

There will also be forms and documents we will ask you to complete periodically. Please update those documents every time your demographic information changes, as it is imperative that we have the most recent information about you on file.

We require **5-7 business days** to complete forms for school, sports physicals, daycare, shot records, disability, etc. Excuses for the day of the visit are available at the checkout desk. If a longer absence is expected, please discuss this with the provider.

Payment

We participate with a variety of insurance plans and **require proof of insurance at each visit**, including Medicaid cards. In order to expedite your claim, we request co-pay at the time of service, and/or a deductible, if it is required by your insurance plan. Noncompliance may result in dismissal from the clinic. Remember, it is your responsibility to know the level of coverage provided by your insurance plan.

We participate with Traditional Medicare part A & B and Blue Care Medicare Advantage. Medicare deductibles and co-insurance are expected at the time of the visit. We accept cash, personal checks, and credit cards (Visa, Master Card, Discovery, and American Express).

Customer Service

Periodically, you may receive a survey in the mail for you to provide us with feedback about our services. This survey is completely confidential and we would certainly appreciate if you could complete it and mail it back. These surveys allow us to continue improving our processes to serve you better and to celebrate our successes based on your responses. **We are here for your family and you!**

Thanks again for trusting us with your medical care. We look forward to a healthy relationship with you and your family.

Carolinas Physicians Network

Patient Registration-Adult

ORG# _____

MRN# _____

	Patient	Parent/Responsible Party- if different Patient Relationship ☐ Child ☐ Spouse ☐ Other
Legal Last Name		
Legal First Name, Middle		
Nick Name		
SSN		
Date of Birth		
Sex	☐ Male ☐ Female	
Marital Status	☐ Single ☐ Married ☐ Divorced ☐ Widow	
Address		
Apt/Bldg/Suite #		
City, State, Zip		
Home Phone		
Work Phone		
Mobile Phone		
Email Address		
Employer Name		
Address		
City, State, Zip		

Emergency Contact	Reason for visit _____
Name	
Home Phone	
Work Phone	Who referred you? _____
Mobile Phone	Permission to leave voice mail @ primary phone number? ☐ Yes ☐ No

	Primary Insurance	Secondary Insurance
Insurance Company		
Primary Policyholder Name		
Primary Policyholder DOB		
Primary Policyholder Sex	☐ Male ☐ Female	

Primary Care Physician _____

If none, do you need help finding a Primary Care Physician? ☐ Yes ☐ No

Authorization, Assignment of Benefits, and Referral Medical Release

I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and complaint resolution. I authorize payment directly to Carolinas Physicians Network for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. A photocopy of this authorization shall be considered as effective and as valid as the original.

Signed: _____ Date: _____

Request for Treatment:

The Group maintains personnel and facilities to assist my physicians in providing my medical care, and I authorize the Group personnel to perform the care ordered by my physicians. I understand that I have the right to be informed by my physicians of the nature and purpose of any proposed procedure and any available alternative methods of treatment, together with an explanation of the risk associated with each procedure. This form is not a substitute for such explanations, which are the responsibility of my physicians to provide according to recognized standards of medical practice, and I acknowledge that the Group and its personnel are responsible for providing this information.

Signed: _____ Date: _____

Date _____

Adult Patient History

Chart # _____
MRN # _____

Name: _____ Age: _____ Date of Birth _____ Sex: M F

Marital Status: Single Married Widowed Divorced Occupation: _____

Spouse/Significant Other Name: _____ Education: Highest Level Completed _____

What is the reason for your visit today? _____ Who referred you? _____

Vaccines	Approximate Date
Tetanus	
Flu	
Hep B	
Pneumovax	
MMR	
Chicken pox	
TB skin Test	Positive Negative

Exams	Approximate Date
Last Dental Exam	
Last Eye Exam	
Last Chest X-ray	
Last Colonoscopy/Sigmoidoscopy	
Last mammogram	
Last Pap Smear	
Last Physical Exam	
Last Prostate Exam/PSA	
Other _____	

FAMILY HEALTH HISTORY:

Check (✓) under the relationship of the blood relative if they have or have had any of the following:

CONDITION	MOTHER	FATHER	MOTHER'S MOTHER	FATHER'S MOTHER	MOTHER'S FATHER	FATHER'S FATHER	BROTHER	SISTER
Heart Disease (Heart attack/blockage, etc.)								
Lung Disease (asthma, bronchitis, emphysema, TB, etc.)								
Cancer (breast, prostate, melanoma, leukemia, etc.)								
Stroke								
High Blood Pressure								
Diabetes								
Liver disease (hepatitis, cirrhosis, jaundice, etc.)								
Kidney disorders (including kidney stones)								
Arthritis								
Blood disorders (anemia, bleeding disorders, etc.)								
High Cholesterol								
Stomach/Intestinal disorders/gall bladder								
Thyroid disorders (goiter, gout)								
Skin disorders								
Depression or other Mental Illness								
Sexually transmitted disease (HIV, Herp., PID, etc.)								
Migraines/Headaches								

Current medications - Prescription and Over-The-Counter Meds. (including vitamins, herbs, aspirin, antacids, injectables, hormones, and birth control)	Are you allergic to any medicine? ☐Yes ☐ No Please list all medications and reactions

Do You	Yes	No	Type	Amt./Day	Date Quit
Use Tobacco products	☐	☐			
Consume Alcohol	☐	☐			
Drink caffeine	☐	☐			
Use or used illegal drugs	☐	☐			
Exercise regularly	☐	☐			
Have diet restrictions	☐	☐			
Travel outside US	☐	☐			

Past hospitalizations/surgeries/serious injuries (including blood transfusions)

SEE REVERSE SIDE

Today's Date _____ Chart # _____

Name: _____ MRN # _____

IN THE PAST MONTH HAVE YOU HAD:

GENERAL

	Yes	No
1. Frequent infections	☐	☐
2. Weight change	☐	☐
3. Appetite/thirst change	☐	☐
4. Excessive fatigue/nervousness	☐	☐
5. Difficulty sleeping	☐	☐
6. Enlarged/tender lymph nodes or glands	☐	☐
7. Other _____		

EYES

	Yes	No
1. Do you wear glasses/contacts	☐	☐
2. Vision changes	☐	☐
3. Red/itchy, watery eyes	☐	☐
4. Eye pain	☐	☐
5. Glaucoma	☐	☐
6. Dry eyes	☐	☐
7. Other _____		

EARS

	Yes	No
1. Infections	☐	☐
2. Hearing loss	☐	☐
3. Earaches	☐	☐
4. Ear drainage	☐	☐
5. Buzzing/ringing	☐	☐
6. Feel "stopped up"	☐	☐
7. Other _____		

NOSE AND THROAT

	Yes	No
1. Nasal stuffiness/drainage	☐	☐
2. Frequent nosebleeds	☐	☐
3. Sore throat	☐	☐
4. Mouth sores/ulcers	☐	☐
5. Hoarseness	☐	☐
6. Changes in taste	☐	☐
7. Teeth/gum problems	☐	☐
8. Snoring	☐	☐
9. Sleep apnea (stop breathing while sleeping)	☐	☐
10. Other _____		

PULMONARY

	Yes	No
1. Shortness of breath/difficulty breathing	☐	☐
2. Cough-dry/productive	☐	☐
3. Asthma/wheezing	☐	☐
4. Night sweats	☐	☐
5. Fever/chills	☐	☐
6. Other _____		

CARDIOVASCULAR

	Yes	No
1. Heart attach/failure/angina	☐	☐
2. Chest pain/tightness	☐	☐
3. Irregular heartbeat	☐	☐
4. High blood pressure	☐	☐
5. Swelling of feet/ankles	☐	☐
6. Leg cramps with walking	☐	☐
7. Mitral Valve/Murmur	☐	☐
8. Other _____		

GASTROINTESTINAL

	Yes	No
1. Heartburn/indigestion	☐	☐
2. Difficulty swallowing	☐	☐
3. Stomach pains/ulcers	☐	☐
4. Nausea/vomiting	☐	☐
5. Vomiting blood	☐	☐
6. Loose stools/diarrhea	☐	☐
7. Constipation	☐	☐
8. Hemorrhoids	☐	☐
9. Rectal bleeding	☐	☐
10. Black/bloody stools	☐	☐
11. Changes in bowel habits	☐	☐
12. Frequent laxatives	☐	☐
13. Liver problems/jaundice/ hepatitis	☐	☐
14. Gallstones	☐	☐
15. Other _____		

BREAST

	Yes	No
1. Lumps	☐	☐
2. Pain	☐	☐
3. Discharge	☐	☐
4. Other _____		

MALES ONLY

	Yes	No
1. Prostate problems	☐	☐
2. Sexual difficulties	☐	☐
3. Testicle pain/lumps/swelling	☐	☐
4. Impotent	☐	☐
5. Discharge	☐	☐
6. Do you do regular testicle exams	☐	☐
7. Date of last prostate exam/PSA _____		
8. Venereal disease	☐	☐
9. Genital concerns	☐	☐
10. Other _____		

FEMALES

	Yes	No
1. Excessive menstrual flow	☐	☐
2. Excessive menstrual pain	☐	☐
3. Vaginal discharge/odor	☐	☐
4. Vaginal dryness	☐	☐
5. PMS symptoms	☐	☐
6. Menopause/symptoms	☐	☐
7. Trouble conceiving	☐	☐
8 Problems with pregnancies	☐	☐
9. Sexual difficulties	☐	☐
10. Venereal disease	☐	☐
11. Genital concerns	☐	☐
12. Self breast exams per year _____		
13. Do you use birth control	☐	☐
Type _____		
14. Date of last pap _____		
15. History of Abnormal Pap	☐	☐
Treatment _____		
16. Date of last mammogram _____		
17. Age at onset of periods _____		
18. Frequency of periods _____		

FEMALES ONLY (continued)

	Yes	No
19. Last menstrual period	☐	☐
20. Pregnancies	☐	☐
21. Live births	☐	☐
22. Miscarriages/abortions	☐	☐
23. Other _____	☐	☐

MUSCULOSKELETAL

	Yes	No
1. Joint pain/tenderness	☐	☐
2. Joint swelling/warmth	☐	☐
3. Joint deformity	☐	☐
4. Joint stiffness	☐	☐
5. Muscle pain	☐	☐
6. Back/neck pain	☐	☐
7. Weakness	☐	☐
8. Prone to falls	☐	☐
9. Other _____		

SKIN

	Yes	No
1. Rashes	☐	☐
2. Dry/itchy skin	☐	☐
3. Bruising	☐	☐
4. Sweats	☐	☐
5. Mole/lesion changes	☐	☐
6. Skin color changes	☐	☐
7. Skin growths	☐	☐
8. Hair/nail problems	☐	☐
9. Other _____		

NEUROLOGIC

	Yes	No
1. Headaches/migraines	☐	☐
2. Dizziness/nausea	☐	☐
3. Fainting/blackouts	☐	☐
4. Numbness/tingling	☐	☐
5. Paralysis	☐	☐
6. Seizures/convulsions	☐	☐
7. Coordination problems	☐	☐
8. Memory loss	☐	☐
9. Other _____		

PSYCHIATRIC

	Yes	No
1. Mental illness	☐	☐
2. Anxiety	☐	☐
3. Depression	☐	☐
4. Suicidal thoughts	☐	☐
5. Overly emotional/mood swings	☐	☐
6. Hallucinations	☐	☐
7. Phobias	☐	☐
8. Other _____		

URINARY

	Yes	No
1. Pain/burning on urination	☐	☐
2. Urinary frequency	☐	☐
3. Difficulty starting urine	☐	☐
4. Incontinence (wetting)	☐	☐
5. Bloody urine	☐	☐
6. Other _____		

Provider Review: _____ Date: _____

ACKNOWLEDGMENT FORM

We are required by law to provide you with our Notice of Privacy Practices which explains how we use and disclose your health information. We are also required to obtain your signature acknowledging that this notice has been made available to you.

☐ I have been provided a copy of CHS' Notice of Privacy Practices.

Signature_____Date_____
(Patient or Authorized Representative)

Relationship to Patient_____

Reason Patient Unable/Unwilling to sign_____

_____

Addressograph

CAROLINAS HEALTHCARE SYSTEM
Written Acknowledgment

File-Medical Records

Carolinas Physicians Network

Carolinas HealthCare System

PAYMENT POLICY & PATIENT STATEMENT OF RESPONSIBILITY

TO OUR VALUED PATIENTS:

THANK YOU for choosing Carolinas Physicians Network for your healthcare services. We strive to provide the highest quality of care yet keep your healthcare costs as low as possible. These policies reflect our efforts to reduce healthcare costs. We appreciate your full cooperation.

FOR YOUR CONVENIENCE we accept any debit or credit card with the MasterCard, Visa, Discover, or American Express logo, as well as your personal check or cash.

PAYMENT (such as co-pays, deductibles & co-insurance) is required at the time of service. We request that you do not ask to be billed. Patients repeatedly asking for exceptions will be directed to a supervisor or practice manager.

INSURANCE CARDS must be presented at each visit. You may feel this is unnecessary, but insurance plans are becoming more complicated, and cards, policy numbers, and renewal dates are constantly changing. In order for us to file your claims with the appropriate plan, we must have the most recent card presented. **If you arrive without your card**, you will be responsible for all charges until the billing office has received complete, current, and accurate insurance information. Most plans require we file your claim within 90 days from the date of service. If we have not received your information within that time, you will remain responsible for all charges incurred up to the date you provide us with your insurance information and we receive payment from the insurance plan. Any balance you owe should be paid within thirty days.

MEDICARE PLANS are more numerous and complicated. Carolinas HealthCare System and Carolinas Physicians Network participate with **Traditional Medicare (Part A & Part B)** only. We do not accept any Medicare Advantage managed care plans except for emergency situations. Please notify the front office immediately if you have recently changed Medicare plans. Medicare deductibles and co-insurance are expected at the time of service. As a participating provider with Medicare, we will file your claim to Medicare and if applicable, to your secondary insurance carrier.

MANAGED CARE PLANS have a network of participating providers. We participate with most major plans, but please contact your plan or check their website or call our office for confirmation before your visit. Applicable co pays, co-insurance and deductibles are expected at time of service. You will also be billed for any non-covered services for which you are liable after your insurance pays their share. If you have a managed care plan that we do not participate with, you will be expected to pay the bill in full at the time of service.

COMMERCIAL INSURANCES are those plans we do not participate in. You will be responsible for payment in full at the time of service. Since we are non-participants in the plan, we do not accept the Usual & Customary fee. As a courtesy, we will file your claim.

WORKER'S COMPENSATION may or may not be accepted by your provider. Please check with your provider before making an appointment. If your provider accepts Worker's Compensation, you will be seen upon approval and authorization by your employer with the proper documentation.

MEDICAID may or may not be accepted by your provider. Please check with your provider before making an appointment. If your provider does accept Medicaid, **you will need to bring your current Medicaid Indentification Card to each visit. These cards are valid for only one month at a time, so it is very important to bring the current month card to your visit.** Failure to bring the current card may result in your appointment being rescheduled. If there is a co-pay with your plan, you will be expected to pay it at the time of service.

HEALTH SAVINGS ACCOUNTS/HEALTH REIMBURSEMENT ACCOUNTS are being promoted so that patients can have more control over managing their health care spending. These accounts will be patient specific so it is important you are aware of all benefits, deductibles, and co-payments. The deductible and co-payment will be expected at the time of service.

SELF PAY PATIENTS are those patients who **do not have any insurance coverage**. Self pay patients will be given a 20% discount off the charges for services provided, if the patient pays their bill in full at the time of service. The discount does not apply to billed services. This discount also does not apply to those patients who may have insurance, but we do not participate with their plan.

MEDICAL LEAVE/DISABILITY FORMS will be completed within 7 to 10 business days upon receiving the form in the office. Please make sure you allow plenty of time for completion of these forms. Emergencies will be handled on a case by case basis. There may also be a fee for completion of these forms.

We thank you for taking time to read and understand our policies. Please let us know if you have any questions. Again, our office should be notified immediately of any changes in insurance coverage or primary care assignment.

I understand my responsibilities as outlined above and will abide by them.

Patient/Guardian Name _____

Patient/Guardian
Signature_____Date_____