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
Name	
Home Phone	
Work Phone	
Mobile Phone	

Reason for visit ____________

Who referred you? ____________

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: ____________

One patient per authorization form

Carolinas HealthCare System

There may be a charge for record copies.

Authorization for Release of Health Information

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that if the organization authorized to receive the information is not an insurance company or health care provider, the released information may no longer be protected by federal privacy regulations.

PURPOSE OF RELEASE: ❑ Ongoing Communication ❑ Copy of Record ❑ Legal or Insurance Review ❑ Authorized Representative's Request ❑ Other ____________________

RELEASE FROM: The facility/practice/individual listed below is authorized to release the requested health information:

Facility/Practice Name: ____________________ **Telephone #:** ____________________

Facility/Practice Address: ____________________ **Fax #:** ____________________

The facility/practice/individual listed above is authorized to release the requested health information for the following: date(s) of service, range of time or event(s): **From:** (MM/DD/YY) ____________________ **To:** (MM/DD/YY) ____________________

CHECK THE SPECIFIC INFORMATION TO BE RELEASED:

❑ All Records & Details
❑ Appointment Information
❑ Billing Information
❑ Consultation Report
❑ Discharge Summary
❑ Emergency Room Records
❑ History & Physical
❑ Immunization Records
❑ Lab/Pathology Reports
❑ Medication Records
❑ Office/Clinic Notes
❑ Operative Report
❑ Physician's Orders
❑ Progress Notes
❑ Psychiatric Evaluation
❑ Radiology/Imaging Reports
❑ Test Results
❑ Other (Please Specify) ____________________

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

NAME OF PATIENT WHOSE INFORMATION IS TO BE RELEASED:

Patient Name: ____________________ (First) ____________________ (Middle/Maiden) ____________________ (Last)

Patient Address: ____________________ (Street Address/PO Box, City, State, Zip)

Social Security #: ____________________ **Date of Birth:** ____________________ **Medical Record/Chart #** ____________________

Please provide phone numbers where you are authorizing CHS to leave patient information as described above:

Home: ____________________ **Work:** ____________________ **Cell:** ____________________

RELEASE TO: This information may be released to and used by the following individuals/organizations. A separate authorization must be completed if the information being released or the purpose differs between the individuals/organizations listed below:

Name	Address	Telephone/Fax #	Relationship

PATIENT'S RIGHTS AND SIGNATURE:

- I understand that I have a right to revoke this authorization at any time by notifying the Medical Record Department of the above named organization in writing. (I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.)
- I understand that authorizing the disclosure of this private health information is voluntary and I can refuse to sign this authorization.
- I understand that I may request to obtain a copy of the information to be used or disclosed per CHS' Notice of Privacy Practices/Policy.
- This authorization will expire when the information from the event/purpose noted above is released to the recipient named in this document.

If the patient is a minor or is clinically unable to sign, an authorized representative may sign this authorization.

PRINT NAME (Patient/Authorized Representative): ____________________

SIGNATURE: ____________________ DATE: ____________________

If Authorized Representative, please indicate relationship to patient: ❑ Spouse ❑ Parent ❑ Guardian ❑ Executor of Estate ❑ Power of Attorney

MINOR'S SIGNATURE: Please note, if the information is relating to the treatment of pregnancy, drug and/or alcohol abuse, venereal disease, or emotional disturbance for a patient under the age of of 18, the patient must also sign this authorization.

NAME OF MINOR: ____________________ SIGNATURE OF MINOR: ____________________ DATE: ____________________

FINANCIAL COMPENSATION: If the requestor of patient information is a health care provider, will the health care provider receive any financial compensation in exchange for using or disclosing the health information described above? ❑ Yes ❑ No ❑ N/A

For Carolinas HealthCare System Use Only: CHS Employees Please Complete

❑ Identification verified ❑ Copy of Authorization given to patient Date of release: ____________ via ❑ Mail ❑ Fax ❑ Other ____________

❑ Accepted - Released information as described above ❑ Partially Accepted - Describe patient information not released: ____________________

Employee Name & Title ____________________

Employee Signature: ____________________ Date: ____________

Carolinas Physicians Network
Carolinas HealthCare System

ACKNOWLEDGEMENT FORM

Medical Records # ________________

Patient's Name: ________________________________ Date of Birth ______/______/______
Day Month Year

We are required by law to provide you with our Notice of Privacy Practices which explain 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.

Signature:____ Date: ____________________
(Patient or Authorized Representative)

Relationship to Patient: _________ Self ___________ Spouse __________ Other ___________

Reason Patient Unable/Unwilling to Sign: ____

____

ACKNOWLEDGEMENT FORM
DOCUMENTO DE RECONOCIMIENTO DE CAROLINAS PHYSICANS NETWORK

Numero de Registro Medico ________________

Nombre del Paciente ___________________________ Fecha de Nacimiento _____/_____/_____
Dia Mes Ano

La ley nos requiere que nosotros le proveamos a usted con nuestro Aviso de Practicas de Privacidad las cuales explican como podemos usar y divulgar su informacion medica. La ley tambien nos requiere que obtengamos su firma, reconociendo que este aviso lo hemos hecho disponible para usted.

Firma: __________________________________ Fecha: ________________________________
(Paciente o Representante Autorizado)

Relacion al Paciente: ________ Mismo _________ Esposo (a) __________ Otro ____________

Razon Por la Cual El Paciente No Puede/No Desea Firmar:______________________________

Carolinas Physicians Network

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)** and a limited number of Private Fee-for-Service (PFFS) Medicare Advantage Plans. We do not accept any Non Private Fee-for-Service 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 and a limited number of PFFS, 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.

OTHER INSURANCES are those plans we do not participate in. You may be responsible for payment in full at the time of service. 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 ____________________

How Did You Hear About Us?

Thank you for choosing the physician practices of Carolinas Physicians Network.
We would appreciate you taking the time to complete this form.

Please select one of the following:

Did you hear about us in one of the following ways:

Community Seminar/Event	Where/When: ______________
Mail	______________
Newspaper Advertisement	Publication: ______________
Patient Resource Center Brochure	______________
Radio Advertisement	Station: ______________
Saw the Facility	______________
Social Services	______________
Television Advertisement	Station: ______________
Web site	______________
Yellow Pages	______________
Other	______________

Whom may we thank for referring you to our practice?

Carolinas HealthCare System Employee	Name: ______________
Employer	Name: ______________
Friend	Name: ______________
Insurance Provider	Name: ______________
Physician Referral	Name: ______________
Relative	Name: ______________

Your Name: ______________________________

Carolinas Physicians Network
Carolinas HealthCare System