Carolinas Physicians Network
Carolinas HealthCare System

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: _____

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 (✔) if you or any blood relative has or has had any of the following and enter their relationship to you: *(Use the following abbreviations)* ***Y - yourself M - mother F - father B - brother S - Sister GF - grandfather GM - grandmother C - child***

Condition	Relationship	Condition	Relationship
Heart disease	_____	Rheumatic fever	_____
Lung disease *(asthma, bronchitis, emphysema, TB, etc.)*	_____	Stomach/Intestinal disorders	_____
Cancer *(breast, prostate, melanoma, leukemia, etc.)*	_____	Gallbladder disorders	_____
Stroke	_____	Thyroid disorders *(goiter)*	_____
High Blood Pressure	_____	Gout	_____
Diabetes	_____	Skin disorders	_____
Liver disease *(hepatitis, cirrhosis, jaundice, etc.)*	_____	Depression or other Mental Illness	_____
Kidney disorders *(including kidney stones)*	_____	Sexually transmitted disease *(HIV, Herp., PID, etc.)*	_____
Arthritis	_____	Alcohol/Drug abuse	_____
Blood disorders *(anemia, bleeding disorders, etc.)*	_____	Risk factors for HIV	_____
High Cholesterol	_____	Migraines/Headaches	_____
Allergies *(food, seasonal)*	_____	Other _____	_____

Current Medications – Prescription and Over-The-Counter Meds.
(including vitamins, herbs, aspirin, antacids, injectables, hormones)

Birth Control ***(Oral, Injectable)***

Are you allergic to any medicine? ☐ **Yes** ☐ **No**
Please list all medications and reactions

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

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	☐	☐			

See Reverse Side

Today's Date _____ Chart # _____

Name: _____ MRN # _____

INDICATE WHICH APPLY TO YOU

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 attack/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 ONLY	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)*

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 stiffness	☐	☐
4. Joint deformity	☐	☐
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: _____

Provider Review: _____ Date: _____

Provider Review: _____ Date: _____

One patient per authorization form

There may be a charge for record copies.

Carolinas HealthCare System

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 HealthCare System

Un Paciente Por Formulario de Autorización | Podría Haber un Costo por Copias de Historiales

Carolinas HealthCare System - Authorization for Release of Health Information Form

Carolinas HealthCare System – Formulario de Autorización para Dar a Conocer Información de Salud

Por medio del presente, autorizo el uso o la revelación de mi información de salud identificable como es descrito abajo. Entiendo que si la organización autorizada a recibir la información no es una compañía de seguro o un proveedor de salud, la información entregada podría ya no ser protegida por las regulaciones federales de privacidad.

PROPÓSITO DE LA ENTREGA: ❑Comunicación en Curso ❑Copia del Historial ❑Revisión Legal o del Seguro ❑Solicitación de un Representante Autorizado ❑ Otro _____

ENTREGA POR PARTE DE: La instalación/consultorio/individuo anotado abajo está autorizado a entregar la información de salud solicitada:

Nombre de la instalación/consultorio: _____ Número Telefónico _____

Dirección de la instalación/consultorio: _____ Número de Fax_____

La instalación/consultorio/individuo anotado arriba está autorizado a entregar la información de salud por lo siguiente: fecha(s) del servicio, margen de tiempo o evento(s): Desde:(mes/día/año) _____ Hasta:(mes/día/año) _____

MARQUE LA INFORMACIÓN ESPECÍFICA A SER ENTREGADA:

❑ Todos los Historiales y Detalles ❑ Resumen del Alta ❑ Reportes de Laboratorio/Patología ❑ Ordenes del Doctor ❑ Notas de Progreso ❑ Otros (Por favor, especifíque) _____

❑ Información de Citas ❑ Historiales de la Sala de Emergencia ❑ Registro de Medicamentos ❑ Evaluación Previa Psiquiátrica _____

❑ Información de Cobros ❑ Historial y Examen Físico ❑ Notas de Oficina/Clínica ❑ Radiología/Reportes de Imágenes _____

❑ Reporte de la Consulta ❑ Registro de Vacunas ❑ Reporte Operatorio ❑ Resultados de Pruebas _____

Entiendo que la información en mi historial médico puede incluir información relacionada a tratamiento de abuso de droga o alcohol, anemia de células falciformes, insuficiencia psicológica o psiquiátrica, enfermedades por transmisión sexual, síndrome de inmunodeficiencia adquirida (SIDA), complejo relacionado al SIDA y/o otros virus de la inmunodeficiencia humana (VIH).

NOMBRE DEL PACIENTE CUYA INFORMACIÓN SERÁ ENTREGADA:

Nombre del Paciente: _____ _____ _____

Primer Segundo/De Soltera Apellido

Dirección del Paciente: _____

(Dirección de Calle/Apdo. Postal, Ciudad, Estado, Código Postal)

Número de Seguro Social: _____Fecha de Nacimiento: _____ Número de Historial/Hoja Médica_____

Por favor, provea los números telefónicos donde usted está autorizando a CHS a dejar la información del paciente descrita arriba:

Casa: _____ Trabajo: _____ Celular: _____

ENTREGAR A: Esta información puede ser entregada a y usada por los siguientes individuos/organizaciones. Una autorización aparte debe ser completada si la información entregada o el propósito difieren entre los individuos/organizaciones anotados abajo:

Nombre	Dirección	Número Telefónico/Fax	Parentesco/Relación

DERECHOS Y FIRMA DEL PACIENTE:

- Entiendo que tengo el derecho de revocar esta autorización en cualquier momento al notificar por escrito al Departamento de Registros Médicos ("Medical Record Department") de la organización mencionada arriba. (Entiendo que la revocación no se aplicará a la información que ya ha sido entregada en respuesta a esta autorización. Entiendo que una revocación no se aplicará a mi compañía de seguro cuando la ley le otorga el derecho de impugnar un reclamo bajo mi póliza.)
- Entiendo que autorizar la revelación de esta información de salud privada es voluntario y puedo rehusarme a firmar esta autorización.
- Entiendo, según el CHS Anuncio de Cómo Manejamos la Privacidad, que puedo solicitar inspeccionar u obtener una copia de la información a ser usada o revelada.
- Esta autorización se vencerá cuando la información del evento/propósito anotado arriba es entregada al destinatario nombrado en este documento.

Si el paciente es menor de edad o es incapaz clínicamente de firmar, un representante autorizado puede firmar esta autorización.

NOMBRE EN LETRA DE IMPRENTA (Paciente/Representante Autorizado): _____

FIRMA: _____ FECHA: _____

Si la firma es de un Representante Autorizado, por favor, indique su parentesco/relación: ❑ Esposo/a ❑ Padre/Madre ❑ Guardián ❑ Testamentario ❑ Apoderado

FIRMA DEL MENOR DE EDAD: Por favor, tome nota, si la información es relacionada al tratamiento de un embarazo, abuso de droga y/o alcohol, enfermedad venérea, o trastorno emocional para un paciente menor de 18 años de edad, el paciente debe también firmar esta autorización.

NOMBRE DEL MENOR: _____FIRMA DEL MENOR: _____ FECHA: _____

COMPENSACIÓN FINANCIERA: Si el solicitante de la información es un proveedor de cuidado de salud, ¿recibirá él alguna compensación financiera a cambio del uso o revelación de la información descrita arriba? ❑ Sí ❑ No ❑ No se aplica

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: _____

_____

CHS Employee Name & Title: _____CHS Employee Signature: _____Date _____

Carolinas Physicians Network

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

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)** 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 not be accepted by your provider. Please check with your provider's office before making an appointment. If your provider does accept Medicaid, **you will need to bring your current Medicaid Identification Card to each 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 insurance coverage.** Self pay patients will be given a 25% discount off the charges for services provided and are expected to pay a minimum of $50.00 at the time of service. This discount also does not apply to those patients who may have insurance, but we do not participate with their plan.

MEDICAL FORMS/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