

Carolina
HEART & LEG CENTER
A Division of CAROLINA CAPE FEAR MEDICAL GROUP, P.A.

3637 Cape Center Dr
Fayetteville, NC 28304
Phone: 910-491-1760 • Fax: 910-491-1764

WELCOME TO OUR OFFICE

Name: _____ Today's Date: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Preferred method of Contact: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Gender: _____ Race: _____ Email Address: _____

Preferred Language: _____ SSN: _____ DOB: _____

Employer: _____

Complete this section only if someone other than the patient is financially responsible:

Responsible Party: _____ Relationship: _____

In Case of Emergency, Contact: _____ Relationship: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Referring Physician or Primary Care Physician: _____

INSURANCE INFORMATION

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company: _____

Where you hurt on the job: _____ Yes _____ No

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, co-pay and non-covered service amounts.

I authorize my insurance benefits to be paid to Carolina Heart and Leg Center, P.A.

I authorize Carolina Heart and Leg Center, P.A. to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

Signature of Patient

Date

3637 Cape Center Drive, Fayetteville, NC 28304

MEDICAL HISTORY

Patient Name: _____		DOB: _____	Gender: _____
Drug Allergies: _____		Allergy to Iodine (X-Ray), Dye, or Shellfish: _____	
Preferred Pharmacy: _____		Pharmacy Phone Number: (____) _____	
DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING: (Please describe as necessary)			
☐ Chest Pain ☐ Angina ☐ Heart Attack ☐ Heart Catheterization ☐ Angioplasty/Stent ☐ Cardiac Bypass ☐ Murmur ☐ Heart Valve Problems	☐ Rheumatic Fever ☐ Heart Failure ☐ Shortness of Breath ☐ Leg Swelling ☐ Heart Rhythm Problems ☐ Palpitations ☐ Dizziness ☐ Fainting	☐ Pacemaker ☐ Defibrillator ☐ Poor Circulation ☐ Leg Pain or Cramps ☐ Angioplasty/Stent to leg artery ☐ Bypass Surgery to Legs ☐ Carotid Artery Blockage or Surgery ☐ Aortic Aneurysm or Surgery	
☐ High Blood Pressure ☐ Diabetes Mellitus ☐ High Cholesterol ☐ Stroke or Mini Stroke ☐ Seizure ☐ Brain Tumor /Aneurysm ☐ Thyroid Problem or Surgery ☐ Emphysema / Asthma ☐ Lung Cancer ☐ Blood Clots in Legs or Lungs	☐ Liver Disease (Hepatitis or Cirrhosis) ☐ Kidney Disease / Kidney Failure ☐ Hemodialysis ☐ Kidney Stones ☐ Fibromyalgia ☐ Lupus or Rheumatoid Disease ☐ Bleeding Problems ☐ Any Cancer : _____	☐ Bleeding Ulcers ☐ Gallstones or Surgery ☐ Acid Reflux ☐ Rectal Bleeding ☐ HIV / AIDS ☐ Anemia ☐ Sleep Apnea	
		Previous Operations: _____	
Personal Habits: Tobacco Use: Cigarettes / Cigar _____/Day Chewing/Snuff Tobacco: ____ Yes ____ No Alcohol Use: Type _____ Amount _____/Day			
Family History: ☐ Heart Disease ☐ Sudden Death ☐ Hypertension	Relationship _____ _____ _____	Age _____ _____ _____	☐ Diabetes ☐ High Cholesterol ☐ Stroke
	Relationship _____ _____ _____	Age _____ _____ _____	

Authorization: I hereby authorize Carolina Heart and Leg Center (physician/staff) to examine me and make such tests and perform such procedures as are reasonable and necessary for diagnosis of my condition and also consent to required treatment. I hereby authorize Carolina Heart and Leg Center, P.A. to release any medical information accumulated in my records during the course of my medical examination or treatment to any doctor, hospital or other health care agency if required so or felt deemed necessary in regard to my health/treatment. In addition, I hereby authorize the release of my medical information contained in any other doctor's office, hospital, or health care agency's records to Carolina Heart and Leg Center, P.A. to facilitate my medical care. I permit a copy of the above to be used in place of the original, which has been filed in the office of Carolina Heart and Leg Center, P.A.

Signature of Patient/Guardian

Printed Name of Patient / Guardian

Date



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TB QUESTIONNAIRE

Patient Name: _____

Date of Birth: _____

[illegible]

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Authorization to Release Information

Patient Name: _____

DOB: _____

I hereby request a copy of my medical records as indicated below, be released to me. **I understand there is a charge for this request, and it is determined by the number of pages requested.**

_____ I elect to have these records mailed to me and understand I may be responsible for any additional postage; records will be ready in twenty-one (21) business days.

_____ I elect to pick these records up in person; records will be ready in twenty-one (21) business days.

_____ I consent to and authorize: _____

Physician/Facility's Name

Fax Number

Address

City

State

ZIP

Phone Number

to release my medical records to, as indicated below Carolina Heart and Leg Center, P.A.

_____ I consent to and authorize Carolina Heart and Leg Center, P.A., to release my medical records as indicated below, to:

Physician/Facility's Name

Phone Number

Fax Number

Address

City

State

ZIP

Please select the specific type of information to be released includes:

_____ History & Physical

_____ Operative / Procedure Report(s)

_____ Consults/Office Notes

_____ Emergency Department Notes

_____ Labs / X-rays / EKGs

_____ Consults, Progress Notes (Hospital)

_____ Other (Specify) _____

I Do _____ I Do Not _____ authorize the release of portions of the record relating to substance abuse, psychological / psychiatric conditions and/or communicable disease, including immunodeficiency virus (HIV), if present.

I understand that I may revoke this consent at any time in writing except to the extent that the information has already been released pursuant to this consent and before I have revoked my consent. Otherwise, this consent shall continue to be valid only for as long as reasonably necessary to carry out the purposes enumerated above or unless it is with release to an Insurance company for payment for medical and/or hospitalization benefits, it will automatically expire one year after date signed, whichever is the earliest date. I have been informed and understand that information disclosed pursuant to this authorization may be subject to re-disclosure by a recipient of such information. It is possible that once disclosed the privacy of the information will no longer be protected under federal medical privacy law.

NOTE: Unless otherwise permitted by law, further release of this information is prohibited without prior written consent.

Signature of Patient or Legal Representative

Date

State Relationship to Patient

Phone Number

Signature of Witness

Date



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Forms Completion Policy

Patient Name: _____

DOB: _____

Carolina Heart and Leg Center, P.A. requires payment for the completion of forms the patient asks us to complete on their behalf. We receive many requests which require increase administrative time and financial resources in excess of what is normally needed to complete the medical records.

Instructions:

- Submit the form completion request well in advance of when they are needed. We will attempt to complete the forms as quickly as possible however, to properly address them we need adequate time to review the patient's records.
- Patient must complete all their information on the form prior to giving the forms to us.
- Provide a stamped, addressed envelope to expedite mailing of completed forms.

We will make every effort to complete these forms within 7-10 business days; however, we cannot make any assurance of completion with the patient's time frame(s). Payment is required prior to completion of all forms.

The following forms will be assessed a \$25 fee for completion:

- FMLA
- Workers Compensation
- Disability
- Letter of Condition
- Miscellaneous Patient request
- The following forms will be assessed a \$10 fee for completion:
- DMV Disability Placard

By signing below, I attest that I have read and understand the above consent. I have been provided of copy of this document for my records.

Signature of Patient or Legal Representative

Date

Printed Name of Patient or Patient Representative

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Consent for Use/Disclosure of Health Information

Patient Name: _____

DOB: _____

Notice of Patient:

By signing this form, you grant us consent to use and disclosure protected health care information for the purposes of treatment, various activities associated with payment and healthcare operations. Our Notice of Privacy Practices provides more detail on our treatment, payment activities and healthcare operations. If there is not a copy of the Notice accompanying this consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your healthcare information.

As stated in our Notice a Privacy Practices, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Noticed. Since revisions may apply to your healthcare information, you have a right to receive a copy by contacting our Privacy Officer.

You have the right to revoke your Consent by giving written notice to our privacy officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this Consent we may decline to treat you.

You are entitled to a copy of this Consent form after you have signed it.

To be completed by Patient or Patient's Representatives

I, _____, have read the contents of this consent form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclosed my healthcare information to carry out treatment, payment activities and healthcare operations.

I, _____, give consent for Carolina Heart and Leg Center, P.A. to speak with _____, in regards to my payment options for patient responsibility. My relationship to this person is _____.

Signature of Patient or Legal Representative

Date

Printed Name of Patient or Patient Representative

Relationship

Our Privacy Officer can be contacted as follows:

Name of privacy officer: Trish Haynes

Practice address: 3637 Cape Center Drive, Fayetteville, NC 28304

Practice phone number: 910-491-1760 FAX: 910-491-1764

This form does not constitute legal advice and covers only had rolled not state laws.

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Financial Policy and Assignment of Benefits

Patient Name: _____

DOB: _____

This document is to inform you of the financial policy established by Carolina Heart and Leg Center, P.A. We are committed to providing you with the best possible care and service; therefore, your complete understanding of our financial policy as it relates to your financial obligations is essential.

If your insurance plan requires you to have an **authorization** for a visit to a specialist office, please make sure your primary care physicians obtain such authorization for the initial visit and subsequent visits. **We are unable to provide service to you without a valid authorization.**

Your insurance plan is an agreement between you and the insurance carrier. You are ultimately responsible for all your medical expenses, and we will look to you for payment of any balances not covered by your insurance. It is the patient/guarantor's responsibility to follow and abide with the policy established by their insurance plans. If your plan requires that you select a specific provider of services, then it is your responsibility to do so and to notify your insurance company of such. If we are participating providers with your insurance plan, all insurance deductibles, copayments and coinsurances are due at the time of service. If we are not a participating provider with your insurance plan you are considered a self-pay patient, and responsible for all charges. We except cash, personal checks, money orders, MasterCard and VISA for payment of services rendered. Carolina Heart and Leg Center, P.A. will not file claims related to motor vehicle accidents or any other liability claims. As a service to our patient's we will bill your charges to your insurance company if you have provided us with the appropriate information. If you have a policy that pays to the patient only, the patient will be responsible for filing the claim. Should there be any unusual financial situations which would make payment difficult, please feel free to discuss this with your account representative. Payment plans are available.

Any patient payment will be first applied to the current co-pay/coinsurance and deductible, and after that the remainder of the payment will be applied to the oldest outstanding balance. Any past due balance (90 days) may be subject to additional collection fees. We reserve the right to refer any account to our collection agency if the account is in default of payment obligation or compliance of this policy. The collection agencies fee will be added to the outstanding balance.

MISSED APPOINTMENTS—If you are unable to keep an appointment please notify us 48 hours prior so that we may use that time for another patient. Medical emergencies or other unforeseen problems could delay your appointment. If this creates any inconvenience, rescheduling is available. If you cancel, reschedule or no show an appointment without giving us 48 hours there will be a **\$25 fee**, for that missed appointment and for each missed appointment thereafter. If you scheduled for testing, there will be a **\$50 fee**. If the appointment is for a Nuclear Stress Test, Peripheral Angiogram or EVLT (Endo Venous Laser Treatment) there will be a **\$150 fee**. These fees must be paid prior to rescheduling the appointment. If you become a chronic no show you will be discharged from the practice.

I hereby authorize Carolina Heart and Leg Center, P.A. to submit appropriate information to my insurance company for processing of my claim(s). I understand that the insurance benefits are paid directly to Carolina Heart and Leg Center, P.A. Furthermore, I agree to and understand that I am directly responsible for all financial obligations to Carolina Heart and Leg Center, P.A. If for any reason I fail to meet my financial obligations forcing Carolina Heart and Leg Center, P.A. to seek further actions as a means of collecting the balance owed (i.e. collection agency/court) I understand that I will be responsible for the balance due on my account plus all collection fees. If my account should be turned over to a collection agency, I understand that until such time that my financial obligations are met, I may no longer be seen as a patient at Carolina Heart and Leg Center, P.A. I further agreed to forever hold harmless Carolina Heart and Leg Center, P.A., their physicians and staff for refusal to render further services in the event I do not honor this financial agreement. I understand that for any services I do not pay in full, at the time the service is rendered; I assign benefits for that claim to Carolina Heart and Leg Center, P.A.

Signature of Patient or Legal Representative

Date

Printed Name of Patient or Patient Representative