

COMMUNITY FAMILY PRACTICE REGISTRATION AND ANNUAL UPDATES FORM (AGES 12+)

Today's Date:	IF UNDER 18 YEARS OLD, PARENT/GUARDIAN'S NAMES: MOTHER'S MAIDEN NAME:		
PATIENT INFORMATION			
Patient's first name:	Middle initial:	Last name:	Date of Birth: Marital status: Employment status:
Gender (current gender identity):	Preferred pronouns (circle one): She/Her He/His They/Their	Former name (if different): Preferred name (if different):	Race: Ethnicity:
Sex assigned at birth:			
Address:			
Social Security no.:	Home phone no.:	Cell phone no.:	
OK to leave message on machine? Yes No		Primary Language Spoken:	
Preferred method of contact for reminders? Text Call		Interpreter needed? Yes No	
EMAIL Address: _____			
*By giving this email address, I consent to being signed up for the Patient Portal.			
PHARMACY:	Do you have Advanced Directives for end-of-life decisions? Yes No If yes, what type? _____ Health Care Power of Attorney Name and Phone Number _____		
INSURANCE INFORMATION			
(IF THE PATIENT'S NAME IS ON THE CARD AND YOU HAVE GIVEN A COPY OF THE CARD TO THE RECEPTIONIST, YOU MAY SKIP THIS SECTION.)			
Subscriber's Name:	Subscriber's DOB (if different):	Address (if different): Phone number (if different): Employer (if applicable):	
Primary Insurance Company:			
Policy number/Subscriber ID:		Group Number:	
Patient's relationship to subscriber:			
Secondary Insurance Company (if applicable): GIVE CARD TO FRONT DESK			
IN CASE OF EMERGENCY			
Name of Emergency Contact:		Relationship to patient:	Phone number:
HIPAA CONSENT: This must be updated yearly. Without signed consent, we can NOT share information regarding your medical care (ex: lab results, appointment dates, etc) or billing to anyone, including family members. Please list anyone that you want to allow to have access to this information.			
1. _____ 2. _____			

SIGNATURE: HIPAA CONSENT, ALL POLICIES, DISCLOSURES, AND CONSENTS including ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES (SEE BACK FOR FULL LIST): (Refusal to sign does NOT prevent responsibility/obligation regarding this office's policies.) I consent to evaluation and treatment by my provider. The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Community Family Practice or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date

Financial Policy, Office Policies, and Signature on File

I authorize the release of any medical pertinent information to my consulting provider, if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of benefits to Community Family Practice, PA.

I understand that I am financially responsible for all services rendered **including** for the following reasons: 1) no proper referral at the time of service or referral is invalid/expired 2) incorrect/invalid insurance information given or failure to give any or new updated insurance information 3) Expenses not covered by insurance including labs 4) deductible not met 5) services rendered deemed medically unnecessary by insurance or non-covered/excluded services by your plan 6) not in network with your plan. ****Failure of insurance company to pay does not excuse patient's financial responsibility. It is patient's responsibility to know what is and is not covered by their insurance policy/plan (including Medicare beneficiaries). Your contract is between you and your insurance carrier. YOU ARE RESPONSIBLE FOR VERIFYING NETWORK STATUS DIRECTLY WITH YOUR INSURANCE CARRIER.** Payment is required for all services at the time they are rendered including co-payments and any outstanding balances. You may be balance billed per your insurance contract guidelines for any amount not collected or known at the time of service. Outstanding balances not addressed/paid in a timely fashion may be forwarded to collections reported to your credit. The billing office may use multiple forms of communication to inform you about your bill, including email, text, and mail. Please inform the office if you wish to unenroll from any of these forms of communication for billing purposes.

Returned Checks: In the event a check is returned for Non-Sufficient Funds, we will assess a \$25.00 charge in addition to your current balance to cover the bank charges incurred by our office due to Non-Sufficient Funds.

Prescriptions: Please bring a list of your current medications with you at the time of your appointment. If you need a prescription refill, please call your pharmacy and ask that they fax a refill request to our office. Our providers will review the request and refill the prescription by return fax or we may request you make a follow up appointment, if necessary. Please allow 48 hours to respond to refill requests.

Missed Appointments: We charge up to \$45.00 for a no-show or late-cancel appointment (less than a 24-hour notice) and for 3 or more rescheduled appointments in a 12-month period. This charge cannot be billed to insurance and will be billed directly to the patient. Please help us to serve you better by keeping all scheduled appointments. Patients that "no-show" or late-cancel 3 appointments within 1 year may be dismissed from the practice.

Inactive Patients: Continuity of care is important. Patients should see their PCP at least once a year. Charts for patients that haven't been seen in 3 years will be automatically inactivated. If the patient chooses to return, they will be considered a new/return patient.

HIPAA:

HIPAA COMPLIANCE STATEMENT - THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. WE COMPLY WITH ALL FEDERAL, STATE, AND LOCAL LAWS. PLEASE REVIEW IT CAREFULLY.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION - Each time you visit our office, we record your symptoms, physical examination, test results, diagnosis, and treatment. This information enables us to plan for your care, communicate with others who care for you, report to your insurance carrier, bill for our work, and improve the quality of our care to you.

YOUR RIGHTS - Although your medical chart belongs to our practice, the information contained in the chart is yours. You have the right to inspect your records, obtain a copy of your chart for a small fee, correct your records, and tell us not to release your information to certain parties.

OUR RESPONSIBILITIES - We are required to maintain the privacy of your health information, send needed health information to other medical providers, and release information to insurance companies, certain government agencies, and others. We may be required to release some information, even without your permission.

EXAMPLES OF HOW YOUR INFORMATION MAY BE USED - Your health information will be recorded and used to plan your treatment. Reports may be sent to other doctors to help them plan your treatment. Claims will be sent to your insurance company. The information in the claims will include confidential information such as your name, address, diagnosis, and treatment. In providing your care, we may communicate with other individuals or businesses. Examples include: other physicians, laboratories, Accountable Care Organizations, and view/share information with the NC Health Information Exchanges (HIE). To protect your privacy, we have business associate agreements with applicable organizations, requiring them to safeguard your information.

OTHER NOTICES - We may leave a message at your home, at your business, on your answering machine or on your voicemail. We may mail you a postcard or other written notices. We may need to disclose your information to your family members or other people helping with your care. In doing so, we will use our best judgment. We may disclose information to others as required by law or if subpoenaed. If you were injured on the job, we will need to disclose your health information to your workers compensation insurance company. We may, from time to time, update these policies.

CUSTODY AGREEMENTS - If you have a child custody agreement/court order, we will need a copy to have on-file. We cannot contact parents separately regarding patient care, unless specifically stated in a legal child custody agreement. Please reference our Divorce/Marital Discord Policy via the practice website communityfamilyonline.com for more information.

FOR MORE INFORMATION, QUESTIONS OR TO REPORT A PROBLEM - If you have concerns or would like additional information, you may contact the Office Manager at 828-254-2444.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES - I have received a copy of the Notice of Privacy Practices for Community Family Practice, PA.

Other Disclosures and Consents:

View and Share Aggregate Data -

I hereby grant consent to CFP to share or view aggregated data with Health Information Exchanges. *If you do not consent, please get a declination form from the front desk.

Authorization to mail, call, text, or email -

I certify that I understand the privacy risks of mail, phone calls, text, and emails. I hereby authorize a CFP representative or my physician to mail, call, text, or email me with communications regarding billing, my health care, including but not limited to such things as appointment reminders, referral arrangements, laboratory results and billing statements. I understand that I have the right to rescind this authorization at any time by notifying CFP to that effect in writing.

Lab/X-Ray/Diagnostic Services -

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services, if they are not reimbursed by my insurance for whatever reason.

Consent to Treatment -

I hereby consent to evaluation and treatment as directed by my CFP physician or his/her designee. Treatment may include but is not limited to: procedures, medications, or vaccines. I hereby consent to CFP obtaining and viewing my prescription and vaccine histories as reported by outside sources.

**** SIGN AND DATE FRONT PAGE ****

Patient Health Questionnaire – 9 (PHQ9):

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things

Not at all Several days More than ½ the days Nearly every day

Feeling down, depressed, or hopeless

Not at all Several days More than ½ the days Nearly every day

Trouble falling asleep, staying asleep, or sleeping too much

Not at all Several days More than ½ the days Nearly every day

Feeling tired or having little energy

Not at all Several days More than ½ the days Nearly every day

Poor appetite or overeating

Not at all Several days More than ½ the days Nearly every day

Feeling bad about yourself, or that you are a failure or have let your family down

Not at all Several days More than ½ the days Nearly every day

Trouble concentrating on things, such as reading or watching TV

Not at all Several days More than ½ the days Nearly every day

Moving or speaking so slowly that other people may have noticed – or the opposite- being so fidgety or restless that you are moving around a lot more than usual

Not at all Several days More than ½ the days Nearly every day

Thoughts that you would be better off dead or hurting yourself

Not at all Several days More than ½ the days Nearly every day

Generalized Anxiety Disorder 7-Item Scale (GAD7):

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Feeling nervous, anxious, or on edge

Not at all Several days More than ½ the days Nearly every day

Not being able to stop or control worrying

Not at all Several days More than ½ the days Nearly every day

Worrying too much about different things

Not at all Several days More than ½ the days Nearly every day

Trouble relaxing

Not at all Several days More than ½ the days Nearly every day

Being so restless that it's hard to sit still

Not at all Several days More than ½ the days Nearly every day

Becoming easily annoyed or irritable

Not at all Several days More than ½ the days Nearly every day

Feeling afraid as if something awful might happen

Not at all Several days More than ½ the days Nearly every day