Marion Wellness & Disease Management, PLLC | 59 Gypsy Mountain Rd Marion, NC 28752 | Office (828) 652-8196 | Fax (828) 652-8186

2021 REGISTRATION FORM (*Please Print Clearly*)

PATIENT INFORMATION

Patient's Full Name (as it appears on insurance card)_____

Name you prefer to be called _____ Email *(Please Print Clearly*_____

Mailing Address _____ City, State, Zip _____

Prefered Phone # (home/cell) _____ Alternate Phone # (home/cell) _____

- Appointment reminders are sent electronically via text message. No other information will be sent via text message. This is a courtesy service. Standard text messaging rates and/or cellular minutes from your mobile carrier may apply (contact your carrier for details). **You can change these preferences at any time with written notice.*
- *Our office may send items by mail, contact you by phone, leave messages on voicemail or with the person who answers the Prefered Phone # you provide above. This communication may include protected health information in accordance with our Notice of Privacy Practices. *You can change these preferences at any time with written notice.*

Patient's Date of Birth _____ Marital Status: ■ Single ■ Married ■ Separated ■ Divorced ■ Widowed

Patient's Social Security # _____ Occupation _____

Patient's Employer _____ Work Phone _____

Person Responsible for Bills (Guarantor) ■ SELF, ■ Other (please print full name): _____

IN CASE OF EMERGENCY

Name _____ Relationship to Patient _____ Phone # _____

- *Our office may contact this person in the event of an emergency or in the event that we are unable to get ahold of you for treatment, billing and healthcare operations. This communication may include protected health information in accordance with our Notice of Privacy Practices. *You can change these preferences at any time with written notice.*

INSURANCE **if the patient is the Insurance Policyholder, you may skip this section*

Policyholder's Full Name (as listed on card): _____ Date of Birth _____

Relationship to Patient _____ Policyholder's Phone # _____

Mailing Address _____ City, State, Zip _____

Policyholder's Employer _____ Employer Phone _____

ASSIGNMENT OF INSURANCE BENEFITS, CONSENT OF TREATMENT, ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE (HIPAA), AUTHORIZATION FOR HEALTHCARE COMMUNICATION & AUTHORIZATION FOR TEXT MESSAGES

✔**ASSIGNMENT OF INSURANCE BENEFITS & CONSENT OF TREATMENT:** I HEREBY ASSIGN my Medicare and/or medical insurance benefits to be paid directly to *Marion Wellness & Disease Management, PLLC* for the services rendered to me by *Kathleen Smothers, MSN, RN, ANP-BC and/or LeAnne M. Roberts, MSN, APRN, FNP-C*, employees or any person providing services through or on behalf of *Marion Wellness & Disease Management, PLLC*. I authorize any holder of medical information about me to release by electronic means or otherwise any medical and/or billing information concerning my care, including copies of my medical records as needed to determine these benefits payable for related services. I understand that I am financially responsible for all non-covered services as well as any deductibles, copay/coinsurance or amounts in excess of insurance benefits. If coverage is denied, I give my express consent to appeal to the insurance on my behalf. I GIVE CONSENT TO *Marion Wellness & Disease Management, PLLC,* its Practitioners, and employees to examine, evaluate and treat as deemed necessary for the above named patient. This assignment and my consent will remain in effect until revoked by me in writing. A copy of this form shall have the same force and effect as the original.

✔**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE:** I acknowledge that I have been presented with a copy of the Notice of Privacy Practices pamphlet, detailing how my information may be used and disclosed as permitted under federal and state law, the duty of *Marion Wellness & Disease Management, PLLC* to protect my health information, privacy rights, including the right to complain to HHS and to *Marion Wellness & Disease Management, PLLC* if I believe my privacy rights have been violated and how to contact *Marion Wellness & Disease Management, PLLC* for more information or to make a complaint.

✔**AUTHORIZATION FOR HEALTHCARE COMMUNICATION:** I GIVE CONSENT TO *Marion Wellness & Disease Management, PLLC* its Practitioners, and employees to send items by mail, contact me by phone, leave messages on voicemail or with the person who answers the Prefered Phone # I provide above. This communication may include protected health information in accordance with our Notice of Privacy Practices. I GIVE CONSENT TO *Marion Wellness & Disease Management, PLLC* its Practitioners, and employees to contact the person(s) I listed as Emergency Contact(s) to discuss my medical information as deemed necessary.

✔**APPOINTMENT REMINDER (BY TEXT) AUTHORIZATION:** I GIVE CONSENT TO *Marion Wellness & Disease Management, PLLC* to send appointment reminders electronically via text message. I understand that this service is offered free of charge. *Standard text messaging rates and/or cellular minutes from my mobile carrier may apply (contact your carrier for details).*

_____ _____

(Signature of patient, parent or legal guardian of patient (Date signed)

_____ _____

(Employee Witness) (Date signed)

Patient Authorization to Disclose, Release and/or Obtain Protected Health Information

INFORMATION TO BE RELEASED FROM: *(Include name of facility/person, address, fax #)*	INFORMATION TO BE RELEASED TO: **Marion Wellness & Disease Management, PLLC** *Kathleen Smothers, MSN, RN, ANP-BC* *LeAnne M. Roberts, MSN, APRN, FNP-C* **59 Gypsy Mountain Rd. Marion, NC 28752** **Phone (828) 652-8196 | Fax (828) 652-8186**

PRINTED PATIENT NAME: _____ **DATE OF BIRTH** _____

Type of Information (*check appropriate box*):

- ☐ Visit notes from date: _____ to date: _____
- ☐ All Medical Records from date: _____ to date: _____
- ☐ Whole Chart
- ☐ Images (*specify, e.g.: radiology, endoscopy*) _____
- ☐ Other (*specify, e.g.: discharge summary, operative reports, lab reports, billing*) _____

Purpose of Disclosure: ☐Health Care ☐Insurance ☐Legal ☐Personal ☐Other (*specify*): _____
*Only records originated through *Marion Wellness & Disease Management, PLLC* will be copied, unless otherwise requested.

I understand that:

- My records may contain private information regarding the diagnosis and/or treatment of illnesses like hepatitis, HIV/AIDS, sexual diseases, substance abuse, and/or mental illness
- *Marion Wellness & Disease Management, PLLC* has no control over how my Protected Health Information will be used by the people who receive it
- *Marion Wellness & Disease Management, PLLC* will not base treatment or payment decisions on receipt of this signed authorization
- I have the right to inspect or obtain a copy of my protected health information and this signed authorization
- A photocopy and/or facsimile of this authorization may be considered as valid as the original
- Fees may be charged for the copying of records in accordance with federal and state laws, there is no charge to send copies of your medical record directly to another health care provider
- Without my express revocation, this authorization will automatically expire upon satisfaction of the need for disclosure; or the following specific date (*optional*): _____
- I can revoke this authorization in writing and that the revocation will not apply to information that has already been released in response to this authorization

By signing this page, I release *Marion Wellness & Disease Management, PLLC* its employees and health care providers from any legal responsibility or liability for this disclosure. I further acknowledge that I have read, understand and agree to the terms above:

_____ ____/____/2021
(Signature of patient, parent or legal guardian of patient) (Date signed)

_____ ____/____/2021
(Employee Witness) (Date signed)

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2021 FINANCIAL/PAYMENT POLICY

Our practice is committed to providing the best treatment to our patients; our prices are representative of the usual and customary charges for our area. To better address questions regarding patient and insurance responsibility for services, we developed this financial/payment policy.

Please read in full. Our billing department is available on-site to answer any questions you may have.

PAYMENT METHOD	It is our policy to collect payment (co-payment, deductible, coinsurance etc.) **at CHECK-IN**. We accept cash, checks, and most debit/credit cards. We also accept debit/credit card payments over the phone. We do not accept postdated checks. If a check is returned, you will be charged a $35 fee in addition to the amount of the check. If you have a second check returned, you will be asked to pay by cash or debit card for all future visits.
SELF PAY	We offer a 20% self-pay discount on all services over $50. Payment in full is expected **at CHECK-IN**. New patients with no insurance are asked to call and speak to our billing department to obtain an estimate.
INSURANCE	Our practice must obtain a copy of **your driver's license and valid insurance card** to provide proof of insurance. We participate in most insurance plans, including Medicare. **If you do not bring your current insurance card, you will be considered a SELF-PAY patient (see above) until we can verify coverage**. If your insurance changes, please notify us before your visit and bring the new card so we can make appropriate changes, otherwise you risk being responsible for the balance of any claim(s) filed under the wrong information.
INSURANCE *Co-payments and deductibles*	It is our policy to collect payment (co-payment, deductible, coinsurance etc.) **at CHECK-IN**. **If you are unable to make your payment according to the terms of your insurance policy, you will be asked to reschedule**. If this happens more than once, all future incidents will be marked as a missed appointment and you will be charged a NO SHOW fee (see missed appointments below) for each. For any questions regarding co-pays/deductible, please contact your insurance company.
INSURANCE *Non-covered services*	**PLEASE BE AWARE:** some services you receive may not be covered by insurance. You may be responsible for the balance of any uncovered services or asked to pay for these services in full at the time of visit. Please be aware any treatment for a chronic or new illness and 'non-preventative' tests or procedures that may be provided during a **Preventive Physical Exam may not be covered by your insurance**. **You will receive separate bills for laboratory and other outside services.** We cannot guarantee that these services are In-Network or covered with your insurance. Please contact your insurance company with any questions
INSURANCE *Claims submission*	**As a courtesy to you**, we will submit your claims and assist you in any way we reasonably can. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request(s). Once your insurance has processed the claim, you will receive a bill from our practice for any outstanding balance. This balance is what your insurance company has determined to be your responsibility and is due upon receipt of the bill. Your benefits are a contract between you and your insurance company; we are not party to that contract. Please contact your insurance company with any questions.
RESCHEDULED, CANCELED AND MISSED APPOINTMENTS	In consideration of our staff and other patients who need to be seen, we ask you to notify us 24 hours prior to your scheduled appointment time if you need to reschedule or cancel your appointment. While we make every effort to provide a courtesy reminder call/text/email prior to your visit, it is your responsibility to cancel your appointment. **A NO-SHOW FEE ($50 or $100 for physicals) will be charged for appointments that are not canceled/rescheduled within 24 hours of appointment time, NO EXCEPTIONS**. If you are more than 15 minutes late for an appointment, **without notice**, your appointment will be considered missed and you will be charged a NO SHOW fee. These charges will be your responsibility and are due prior to your next appointment. More than 3 "NO SHOWS" may result in higher charges and 6 could result in dismissal from the practice.

COPIES OF MEDICAL RECORDS	Your medical records are available through our online Patient Portal **at no cost to you**. If you wish to have a hardcopy of your records, you will be charged for the cost of copying the record and any postage needed. This charge must be paid in full before records are available. [According to NC Statute GS90-411, our fee schedule is $0.75 for pages 1-25, $0.50 for pages 26-100, and $0.25 for pages 101-plus, with a minimum fee of $10.00.] Upon written request (authorization to release medical records), a copy of your medical records can be sent directly to another healthcare provider at no charge.
WORKERS' COMPENSATION LIABILITY / MOTOR VEHICLE ACCIDENTS	**We do not routinely handle WORKERS COMPENSATION or LIABILITY/MOTOR VEHICLE ACCIDENT** cases. You will need to use your health insurance if available or you will be considered self-pay for any visits at this clinic. We can provide you and/or your attorney/liability insurance carrier with a copy of your bill upon your written request so that you can seek reimbursement for expenses.
COMPLETION OF FORMS *Including, but not limited to: Insurance forms, Family Medical Leave Act, disability applications, medical clearance letters, letters of medical necessity, etc.*	An office visit, to determine medical necessity, is required from most of these companies. This visit must be prior to completion of most medical forms. • Due to the increasing volume of forms and letters that are being requested, and the time it takes away from direct patient care we do charge a nominal fee for this service: processing fee $30. • Patients with an outstanding balance will be required to pay balance in full in addition to the processing fee. • Our staff will begin processing the forms for completion after payment is received in full.
LAB RESULTS	Your lab results are available through our online Patient Portal **at no cost to you**. We also offer the option to pick-up a copy of your reviewed lab work 1-2 weeks after your appointment at no cost. If lab results have not been picked up within 2 weeks and/or your portal is not active, results will be mailed to the address on file and there will be a convenience fee of $5 added to your account to cover the cost of copying and postage. This charge must be paid in full before your next visit. To avoid charges, please call the office to set up a portal account.
NONPAYMENT *Delinquent accounts*	Due to the high cost of rendering care and lowered reimbursements we simply cannot afford to carry large balances. Outstanding balances, **over 90 days,** will receive a letter requesting payment in full, within 30 days, to avoid collection action. Please be aware that if your account becomes delinquent, we may refer it to a collection agency. You agree to pay any charges to collect your unpaid bills, including but not limited to, reasonable court costs, and/or collection agency fees. Delinquent accounts may result in your discharge from this practice, you will be notified by certified mail.

By signing the financial responsibility statement, the patient and guarantor(s) acknowledge and agree they are responsible for payment of services rendered or to be rendered. The patient and guarantor(s) guarantee and agree to pay charges for those services rendered including any amount not covered by insurance, Medicare, health service plan or health maintenance organization. This financial responsibility statement will remain in effect until an updated statement is signed and submitted taking its place; or it is revoked by me in writing. A copy of this statement shall have the same force and effect as the original. I acknowledge that I have read and understand the FINANCIAL/PAYMENT POLICY and FINANCIAL RESPONSIBILITY STATEMENT contents fully:

_____ _____/_____/2021

(Signature of patient, parent or legal guardian of patient) (Date signed)

_____ _____/_____/2021

(Employee Witness) (Date signed)

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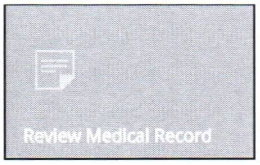
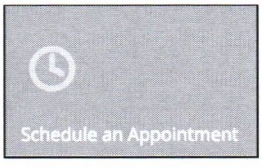
YourHealthFile: PATIENT PORTAL

Marion Wellness & Disease Management, PLLC is committed to providing you with the highest quality of care. To enhance your experience we provide a secure and FREE Patient Portal. **Portal communication is NOT to be used for emergency or urgent medical services:** *CALL 911 IF EXPERIENCING A MEDICAL EMERGENCY*

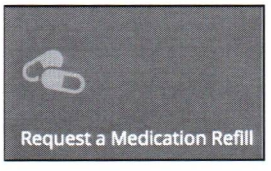


Access your medical record and clinical summaries- Review a detailed summary of your health record and the results of your last office visit, all online.

Secure communication directly with your healthcare team through your portal.
All lab results will be available on YourHealthFile patient portal and **a message will be sent, through "Message a Provider", that will review these labs.**



Convenient self-scheduling through your portal- access to all available appointments in our office for you to choose a day/time that works best for you.



Convenient refill request through your portal- Review all the medications in your health record.

We no longer routinely mail lab results. Please **SELECT ONE** option for how you would like to receive results:

- ❑ I am using the patient portal now and know how to receive messages there; ***STAFF REVIEWED*** ____ (initial)
- ❑ Please sign me up, my email address is: _____
- ❑ I will pick up my results in the office the week after they were completed, results can be given to you or your emergency contact only
- ❑ I would like to have my results mailed to my address on file; **there is a convenience fee of $5 that will be added to your account** to cover the cost of copying and postage

_____

(Signature of patient, parent or legal guardian of patient) (Date signed)

WHAT NEXT…

1. We will add your email, then you will receive an email from: HFAlerts@nextgen.com with the subject line **"Activate your YourHealthFile Patient Portal account"** *TIP: this email expires after a few days
2. Click the link in the email to register, answer the questions and then…..
3. After you've registered, go to **YourHealthFile.com** and log in with the username and password you chose, explore and bookmark the site. That is your Patient Portal. *TIP: Our system does not work with Internet Explorer, Supported browsers include: Mozilla Firefox, Google Chrome and Safari

**TIP: write down the username and password you pick so you don't forget it*

MY USERNAME:
MY PASSWORD:

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YourHealthFile: PATIENT PORTAL

Patient Portal **Proxy Access Request**, Authorization and Acceptance

***** This is <u>OPTIONAL</u>, only needed if you chose to have someone else have access to your portal *****

If you are an adult patient of *Marion Wellness & Disease Management, PLLC*, you can use this form to request and authorize "Proxy Access" **to allow an adult family member or other person involved in your medical care to access, view and manage certain information in your medical record through your Patient Portal**. You can authorize more than one person to have access to your Patient Portal, but you must complete a <u>separate form for each request</u>.

Your proxy can see everything in your medical record that you can see through your Patient Portal. In fact, after your Proxy is granted access, he/she would be able to access, view and manage your Patient Portal in the same way you can, including seeing your lab or test results, viewing and requesting appointments, as well as managing and updating your personal information. The information your Proxy would see would also include any information relating to the diagnosis and/or treatment of mental illness, alcohol/drug abuse, STDs, HIV/AIDS related information, developmental disabilities, and genetic testing results.

What If I Change My Mind Later? If you change your mind you must inform us immediately that you wish to terminate your Proxy's access to your Patient Portal. If your relationship with your Proxy changes, <u>it is your responsibility to let us know if you need to terminate your Proxy's access</u> to your medical record. If you do not let us know, your Proxy will continue to have access to your medical record as you authorized by this form.

My (Patient) Name: _____ **Patient's** Date of Birth: _____

Proxy Name: _____ *Proxy* Phone Number: _____

Proxy E-mail: _____

Proxy Relationship to the Patient: ☐ Spouse ☐ Adult Child ☐ Other: _____

Expiration Date/ Right of Revocation of Authorization: This authorization will remain in effect unless revoked or terminated by the patient in writing to *Marion Wellness & Disease Management, PLLC.*

Neither *Marion Wellness & Disease Management, PLLC* or its employees are liable for any unauthorized access to your health information that may result from you and your Proxy not protecting your access credentials. By signing below, I confirm all of the representations and warranties above, and hereby authorize my Proxy to have full access to my medical information:

_____ _____

Patient Signature (or Legal Guardian, if patient minor or incapacitated) Date

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PATIENT HEALTH HISTORY: HIGHLIGHTED AREAS REQUIRED

NAME: _____ **AGE:** _____ **Today's Date:** _____

MEDICAL HISTORY & FAMILY MEDICAL HISTORY

Please write **NOW** or **PAST** for your significant medical history AND **WHICH FAMILY MEMBER**

(Example: Mom, Dad, Sis, Bro, M-GM, M-GF, P-GM, P-GF, M-aunt, P-aunt, P-aunt, P-uncle, Son, Daughter)

	SELF	FAMILY MEMBER		SELF	FAMILY MEMBER		SELF	FAMILY MEMBER
Example	**NOW**		**Example**	**PAST**	**M-GF**	**Example**		**Sis.**
Loss of hearing			Hemorrhoids			Depression		
Ringing in ears			Hernia			Suicidal thoughts		
Frequent ear infections			Gall bladder problems			Other mental illness		
Vision problems			Nausea			Urination Problems		
Glaucoma			Vomiting			Frequent urination		
Nose bleeds			Sudden weight loss/gain			Kidney stones		
Chronic sinus trouble			Liver disease			Kidney disease		
Frequent sore throat			Hepatitis			Cancer- Breast		
Significant Allergies			High cholesterol			Cancer- Colon		
Hoarseness			Diabetes			Cancer- Lung		
Pneumonia			Hypoglycemia			Cancer- Prostate		
Chronic bronchitis			Thyroid disease			Cancer- Ovarian		
Asthma			Bleeding/clotting disorder			Cancer- Skin		
Shortness of breath			Osteoporosis			Cancer- Other		
Tuberculosis			Leg cramps			Polio		
Heart murmur			Joint Pain			Mumps/Measles		
Palpitations			Arthritis			Chicken Pox		
Irregular heart beat			Back pain			STI/STD:		
Swollen ankles			Broken bones			OTHER:		
Chest pain			Gout					
High blood pressure			Rashes					
Heart Attack			Skin changes					
Stroke			Varicose veins					
Anemia			Dizzy spells					
Trouble swallowing			Fainting spells					
Indigestion/Heartburn			Memory loss					
Reflux/GERD			Seizures/Epilepsy					
Stomach ulcer			Migraines / Headaches					
Chronic Diarrhea			Fatigue					
Constipation			Problems with sleep					
Bloody/tarry stools			Nervous / Anxious					

MEN ONLY

Changes in urine stream? **YES NO**
Prostate problems? **YES NO**
Pain/Lump in Testicle? **YES NO**
Pain or problems with sex? **YES NO**
Monthly Testicular Self-Exam? **YES NO**
Other Problems _____

WOMEN ONLY

Last period _____ Regular / Irregular
Birth Control Method _____
Abnormal Bleeding? **YES NO**
Pain or problems with sex? **YES NO**
Monthly Breast Self-Exam? **YES NO**
Other Problems _____

Alcohol use, NEVER / PAST / CURRENT:
___Drinks Yearly
___Drinks Monthly
___Drinks Weekly
___Drinks Daily
Type of alcohol used: _____

Tobacco use, NEVER / PAST / CURRENT:
Type of tobacco used: _____
How much: _____
For how many years? _____

Illegal Drugs, NEVER / PAST / CURRENT:
Type of drug used: _____
How much: _____
Last use: _____

Anything not listed above or comments you would like to add about yours or your family members health: _____

SURGICAL / HOSPITAL HISTORY

Please list any illness/operations you've had that required a stay in the hospital (not including pregnancies)

YEAR	Illness / Operation and Hospital Name	YEAR	Illness / Operation and Hospital Name

PATIENT HEALTH HISTORY *(continued)* HIGHLIGHTED AREAS REQUIRED

PREVENTATIVE CARE

Please list the year last done and circle if normal or abnormal

Test	Year	Result (Please Circle)	Test	Year	Result (Please Circle)
Vision Exam (by eye doctor)		Normal / Abnormal	Women: Pelvic / Pap		Normal / Abnormal
Dental exam / cleaning		Normal / Abnormal	Bone Density Scan		Normal / Abnormal
Colonoscopy		Normal / Abnormal	Last Physical (Annual Wellness)		Normal / Abnormal
Women (age 40+): Mammogram		Normal / Abnormal	Men (age 40+): Prostate exam		Normal / Abnormal

When was your last checkup at a doctors office?	**When was the last time you had blood work completed?**
What year was your last Tetanus Shot , Tdap or Td?	Have you had a pneumonia shot? **NO YES: When?** _____
Have you had a shingles shot? **NO YES: When?** _____	When was your last Flu Shot? .

MEDICATIONS

Please list **all** medication you are now taking

**including over the counter medications, vitamins, herbs and other supplements

Preferred Pharmacy	Located in (City)

MEDICAL ALLERGIES

I prefer a ▫ **90-day** (3 month) or ▫ **30-day** (1 month) supply of my daily prescription medication(s)

Medication Name	Strength	Frequency	Reason taking

By signing below, I agree that the information I am providing is accurate and up-to-date to the best of my knowledge AND I will update *Marion Wellness & Disease Management, PLLC* of any changes as soon as possible

Signature: _____ Today's Date: _____