TELL US WHERE YOU HEARD ABOUT OUR PRACTICE

WHETHER YOU ARE A PATIENT THAT HAS NOT SEEN US IN SEVERAL YEARS OR A PATIENT NEW TO OUR PRACTICE; WE WANT TO KNOW WHY YOU CHOOSE US TO PROVIDE YOUR MEDICAL CARE

HAVE YOU SEEN OUR ADVERTISING AT ANY OF THE FOLLOWING LOCATIONS (PLEASE FEEL FREE TO CHECK MORE THAN ONE)

_____WORD OF MOUTH, FRIENDS/FAMILY

To whom may we thank for the referral,_____

Names of patients will never be given but we would like to be able to thank others

_____NE.WSPAPER AD OR ARTICLE

_____ATHLETIC EVENTS/BANNERS/PROGRAM SPONSHORSHIPS

_____PHONE BOOK

_____CHATUGE WEBSITE (WWW.CHATUGEFP.ORG)

_____ER OR HOSPITAL FOLLOW UP/REFERRAL

_____FACEBOOK OR OTHER SOCIAL MEDIA WEBSITE

_____OTHER _____

For Demographic purposes please list your AGE:_____

Chatuge Family Practice

REGISTRATION FORM

(Please Print on line below question)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status (cirde one) Single / Mar / Div / Sep / Wid

Is this your legal name?	If not, what is your legal name?	(Former name):	Birth date:	Age:	**Sex:**
☐ Yes ☐ No			/ /		☐ **M** ☐ F

Street address:	Social Security no.:	Home phone no.:
		( )

P.O. Box:	Qty:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.:
		( )

Cell phone no.: ( )	**E-Mail Address:**	Preferred Pharmacy:

Race:	Ethnicity:	Preferred Language:	

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
	/ /		( )

Is this person a patient here?	☐ Yes	☐ No		

Occupation:	Employer:	Employer address:	Employer phone no.:
			( )

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance ☐ Medicare ☐ NC Medicaid ☐ Blue Cross Blue Shield ☐ United Healthcare ☐ Aetna

☐ Cigna Healthcare ☐ Crescent Network ☐ Medcost Network ☐ Medicare Alternative (PFFS) ☐ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:
		/ /			$

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )

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 Chatuge Family Practice or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

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Chatuge Family Practice

Patient Consent to the Use and Disclosure of Health Information For the Treatment, Payment, or Healthcare Operations

I,_____, understand that as part of my health care, Chatuge Family Practice maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnose, treatment, and any plans for future care or medical treatment. This record is also used as a source for applying coding information for my account.

I have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to restrict the use of my health information regarding any disclosure to carry out treatment, payment, or other health care operations.

I understand that Chatuge Family Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations and would be unable to bill any insurance carrier.

I further understand that Chatuge Family Practice reserves the right to change their Notice of Information Practices and prior to the implantation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Chatuge Family Practice change their notice, they will notify me accordingly by an updated notice when I revisit the office.

In my absence, I authorize Chatuge Family Practice to discuss my health information or account information with:
(list names of spouse, children (over the age of 18), friends, relatives, etc.)
Your information cannot be discussed with anyone NOT on this list.

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to other physicians, laboratories, insurance companies, or other entities, in regards to my medical care and collection of payment for services rendered. I consent to such disclosures for these permitted uses, including disclosures via fax. I authorize Chatuge Family Practice to leave messages that will identify the caller and the office they are calling from on an answering machine that I provided. Please note that medical information will not be left on the machine. In your absence, a message will be left to call the office back to obtain this information.

I understand and accept the terms of this consent.

_____ _____

Patient/Parent/Guardian/POA Signature Date

Chatuge Family Practice
241 Church Street; PO Box 1309
Hayesville, NC 28904
(828) 389-6383

PATIENT FINANCIAL POLICY

Thank you for choosing Chatuge Family Practice as your healthcare provider. We are dedicated to fostering a successful physician-patient relationship with you and your family. A clear understanding of our Patient Financial Policy is crucial to this professional relationship. Payment for services rendered is an essential component of that relationship. Should you have any questions regarding our fees, policies, or your responsibilities, please do not hesitate to ask. It is also your responsibility to inform our office of any changes to patient information (e.g., address, name, insurance details).

1. **Payment at Time of Service**: All charges are due at the time services are provided. If an emergency arises or you are unable to pay in full at that time, please arrange this in advance with our billing department.
2. **Insurance Filing**: We will gladly file your insurance claims under most circumstances. It is essential to provide current and accurate information regarding your insurance plan. You are responsible for verifying whether our practice participates with your insurance provider. If this verification is not completed at the time of your appointment, you will be liable for the full charges.
3. **Referrals and Preauthorizations**: If your insurance company requires a referral and/or preauthorization, it is your responsibility to obtain these. Failure to secure the necessary referral and/or preauthorization may result in reduced or no payment from your insurance as well as delay in healthcare, making you responsible for the remaining balance.
4. **Hospital and Emergency Visit Charges**: Charges for hospital and emergency visits will be submitted to most insurance companies. If the insurance company does not respond within 60 days of our filing, the charges will be sent directly to you, and you will be responsible for payment.
5. **Responsibility for Charges**: For services rendered to children of divorced parents, the parent who seeks treatment for the child will be responsible for the associated charges. Payment is due at the time of service, regardless of any court orders.
6. **Returned Check Fee**: A fee of $35 will be charged for returned checks, payable by cash, credit card, or money order. This fee will be applied to your account in addition to the original amount of insufficient funds. Following any returned check, you may be placed on a cash-only basis.
7. **Appointment Cancellation**: A 24-hour notice is required for any appointment cancellations. Failure to provide this notice will result in a $35 no-show charge, which must be paid before scheduling any future appointments. After three no-show appointments, you may be dismissed from our practice.
8. **Medical Records Request**: A minimum charge of $12.00 is required in advance for any medical records you request. Fees may be higher depending on the volume of records.
9. **Co-Pay for MAP/PCAP Patients**: If you are a MAP/PCAP patient, you are required to pay your co-pay at the time of service.
10. **Outstanding Balances**: If you have an outstanding balance with our practice, you must pay this balance in full before we can schedule another appointment for you.
11. **Behavior Policy**: Chatuge Family Practice, its medical staff, and any associated programs will not tolerate obscene, belligerent, threatening, or inappropriate behavior, including shouting or raising one's voice unnecessarily. Any such behavior will be reported to your provider for review, which may lead to dismissal from our practice.

Thank you for your understanding and cooperation.

_____ _____

Patient Signature Date

Chatuge Family Practice
241 Church Street; PO Box 1309; Hayesville, NC 28904
Phone: (828) 389-6383 Fax: (828)537-1221
www.chatugefp.org

Patient Consent for Electronic Prescribing

Chatuge Family Practice has implemented e-prescribing as part of an on-going effort to improve your health care. E-prescribing refers to a system used to submit prescriptions electronically to yourpharmacy.

By signing below, you provide your consent for Chatuge Family Practice and its providers to electronically submit your prescriptions through the e-prescribing system described above and torequest and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payors for treatment purposes.

This consent will remain in effect until you withdraw it. You may withdraw your consent at any time except to the extent it has already been relied upon. Your decision not to sign this form will affect your ability to receive medical care or your ability to receive your prescriptions through alternative means.

Patient Name:_____

Patient or Guardian Signature: _____

Relationship to Patient (for guardian signatures):_____ **Date:**_____

Notice of Medical Treatment

By signing below I acknowledge that Chatuge Family Practice will not prescribe narcotics (Percocet, Norco, Vicodin, etc.) or other pain medications to me. I understand they will not prescribe benzodiazepines (i.e... Xanax, Ativan, Valium, etc.) or antipsychotics. I understand to receive these medications I will need to find a separate provider.

I also agree to let my provider at Chatuge Family Practice know if I am prescribed thesemedications by an outside Provider.

_____

Patient Name: Date:

_____

Patient Signature

NEW PATIENT
MEDICAL HISTORY FORM

Full Name: _____ Date: _____

Birth Date: _____ Age: _____

ALLERGIES ☐ NO ALLERGIES

ALLERGY	ALLERGIC REACTION

MEDICATIONS/SUPPLEMENTS ☐ NO MEDICATIONS

MEDICATIONS *(Please list ALL)*	DOSE *(Mg., pill, etc.)*	TIMES PER DAY

If you need more room to list medications, please write them on a blank sheet of paper with the required information

HEALTH MAINTENANCE SCREENING TEST HISTORY

BLOODWORK	Date:	Facility/Provider:
COLONOSCOPY/SIGMOID	Date:	Facility/Provider:
MAMMOGRAM	Date:	Facility/Provider:
PAP SMEAR	Date:	Facility/Provider:
BONE DENSITY	Date:	Facility/Provider:

VACCINATION HISTORY

Last Tetanus Booster or TdaP:	Last Pnuemovax *(Pneumonia)*:
Last Flu Vaccine:	Last Prevnar:
Last Zoster Vaccine *(Shingles)*:	Last Covid Vaccine:

PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Asthma			
Cancer *(type:_____)*			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes *(type:_____)*			
Emphysema *(COPD)*			
Heart Disease			
High Blood Pressure *(hypertension)*			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Renal *(kidney)* Disease			
Migraine Headaches			
Stroke			
Other:			
Other:			

SURGERIES

TYPE *(specify left/right)*	DATE	LOCATION/FACILITY

WOMEN'S HEALTH HISTORY

Date of Last Menstrual Cycle:	Age of First Menstruation: ___ Age of Menopause: ___
Total Number of Pregnancies:	Number of Live Births:
Pregnancy Complications:	

Patient Name: _____ DOB: _____

FAMILY MEDICAL HISTORY ☐ NO SIGNIFICANT FAMILY HISTORY IS KNOWN

CHECK ALL THAT APPLY	Alcohol/Drug Abuse	Asthma	Cancer (type:)	Emphysema (COPD)	Depression/Anxiety	Bipolar/Suicidal	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke	Thyroid Disease	Migraines	Other:_____	Other:_____	Other:_____
Mother																		
Father																		
Brother																		
Sister																		
Child																		
Maternal Grandmother																		
Maternal Grandfather																		
Paternal Grandmother																		
Paternal Grandfather																		
Other:_____																		

SOCIAL HISTORY

Occupation *(or prior occupation)*:	☐ Retired ☐ Unemployed ☐ LOA ☐ Disabled
Employer:	Years of Education or Highest Degree:
If employed, do you work the night shift? Y ☐ N☐ N/A☐	
Marital Status *(check one)*: ☐ Single ☐ Partner ☐ Married ☐ Divorced ☐ Widowed ☐ Other:_____	
Do you have children? Y☐ N☐	If yes, how many?

OTHER HEALTH ISSUES

TOBACCO USE	Smoke Cigarettes? Y ☐ N ☐ *(If you never smoked, please move to Alcohol /Drug Use)*		
Current: Packs/day ___ # of Years ___	***Past:*** Quit Date: _____ Packs/day ___ # of Years ___		
Other Tobacco *(check one)*: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew ☐ Vape			
ALCOHOL/DRUG USE	Do you drink alcohol? Y☐ N☐	☐ Beer ☐ Wine ☐ Liquor	# of Drinks/week:
Do you use marijuana or recreational drugs? Y ☐ N☐	Have you ever used needles to inject drugs? Y☐ N☐		
Have you ever taken someone else's drugs? Y☐ N☐			

Patient Name: _____ DOB: _____

OTHER HEALTH ISSUES continued...

SEXUAL ACTIVITY	Sexually involved currently? Y□ N□ *(If no sexual history, please continue to Exercise)*	
Sexual partner(s) is/are/have been: □ Male □ Female		
Birth control method: □ None □ Condom □ Pill/Ring/Patch/Inj/IUD □ Vasectomy		
EXERCISE	Do you exercise regularly? Y□ N□ *(If you answered no, please move to Sleep)*	
What kind of exercise?	***Duration:*** How long (min.): _____ How often: _____	
SLEEP	How many hours, on average, do you sleep at night *(or during the day, if working night shift)*?	
DIET	How would you rate your diet? □ Good □ Fair □ Poor	Would you like advice on your diet? Y□ N□
SAFETY	Do you use a bike helmet? Y□ N□	Do you use seat belts consistently? Y □ N □
Working smoke detector in home? Y □ N □		If you have guns at home, are they locked up? Y□ N□
Is violence at home a concern for you? Y □ N □		Have you completed an Advance Directive for Health Care (ADHC), Living Will, or Physical Orders for Life Sustaining Therapy (POLST)? Y □ N □

OTHER PROVIDERS/SPECIALISTS

SPECIALIST	NAME	LAST vISIT
Cardiology		
Gastroenterologist (GI)		
OB/GYN		
Neurology		
Pulmonary		
Other:_____		
Other:_____		

ADDITIONAL INFORMATION

Have you traveled outside of the country in the last 30 days? Y □ N □	If yes, where?
Have you served in the military? Y □ N □	If yes, how long and what branch?
Were you deployed? Y □ N □	If yes, where?

Patient Name: _____ DOB: _____