Family Medical Associates of Raleigh
Your Family Comes First

3500 Bush Street
Raleigh, NC 27609
F: 919.875.9577
P: 919.875.8150
www.fmaraleigh.com

Patient Acknowledgment and Consent

MRN:_____

Patient Name:_____ DOB:_____

We are proud to be your Patient Centered Medical Home; please see our brochure in the lobby.
We offer same day appointments, extended office hours, and a provider on call 24/7 for urgent matters.

Consent for Treatment: I consent to treatment, examinations, procedures and diagnostic testing provided by Family Medical Associates of Raleigh (FMAR), which are deemed necessary.

HIPAA: I have been provided access to a copy of the Notice of Privacy Practices. I understand that my medical information may be required for payment of insurance benefits or by specialists that I have been referred to for my ongoing care.

Communication: I authorize FMAR to leave messages regarding my medical treatment at the numbers previously given **except for**: _____. I will notify FMAR if I would like to share my medical treatment information with any individuals and sign a Release of Information Authorization Form.

Prescriptions: I understand I need to provide a 48-hour notice for all medication refills and will notify my physician if I stop taking any medication.

Billing of Wellness Visits and Sick Visits: Visits for preventive wellness care such as adult physicals and Medicare wellness visits are separately billed from diagnostic and disease management care. I understand that additional evaluation of new problems, follow ups, and chronic conditions may be billed separately and processed at a different benefit level by my insurance than my preventive care.

Financial Responsibility: I have been provided access to a copy of FMAR's financial policy and understand I am financially responsible for all services provided at the time of service, including any amounts not covered by insurance. FMAR will take all necessary and appropriate action to collect any money due, including the use of collection agencies, and/or attorneys. My appointment may be rescheduled if I am unable to pay any current or past due balances.

Pharmacy Benefit Manager: I consent to allow my provider to access my pharmacy benefits, which are part of my insurance plan, in order to evaluate coverage for medications prescribed for me.

Patient Responsibility: I will act in a manner that is respectful of other patients, FMAR employees and clinic property. I will return at least every six months for a face-to-face follow-up visit with my provider if I take any maintenance or routine medications. I will notify my provider prior to stopping any medication prescribed.

Availability of Marketing Materials of Family Health and Wellness: Family Health and Wellness Center is a corporation founded by the owners of FMAR. As such, I acknowledge that FHWC materials, pamphlets, and posters are available throughout the office.

Patient Signature: _____ Date: _____

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Release of PHI Authorization Form
(For Use or Disclosure of Protected Health Information) MRN _____

Patient Name: _____DOB: _____Personal Representative Name: _____

Protected Health Information (PHI) *is information that is created, received, transmitted, or stored by Family Medical Associates of Raleigh which relates to your past, present, or future physical or mental health, health care, or payment for health care, and either identifies you or provides a reasonable basis for identifying you. Except as permitted by law, Family Medical Associates of Raleigh may not use or disclose PHI to persons other than those you specify on this form.*

If you are age 18 and older and you want someone else to also have access to your PHI, pick up prescriptions, speak with your provider or FMAR, or schedule appointments on your behalf, please complete and submit this form to the front office staff.

☐ **DECLINED:** I am declining at this time to allow anyone else, other than myself, to have access to my PHI, pick up my prescriptions, speak with my provider or Family Medical Associates of Raleigh, or schedule my appointments.

I authorize Family Medical Associates of Raleigh to disclose the PHI identified below **(mark all that apply)** to the following person(s)**.** ***These individuals will need to show a picture ID if picking up prescriptions or collecting written documents on your behalf.***

☐ **Spouse**	☐ **Relationship:_____**	☐ **Relationship:_____**
Name:_____	**Name:_____**	**Name:_____**
☐ **Entire PHI**	☐ **Entire PHI**	☐ **Entire PHI**
☐ Immunization Record History	☐ Immunization Record History	☐ Immunization Record History
☐ Office Visit	☐ Office Visit	☐ Office Visit
☐ Appointment Scheduling	☐ Appointment Scheduling	☐ Appointment Scheduling
☐ Lab Results	☐ Lab Results	☐ Lab Results
☐ Prescription Pick Up Requests	☐ Prescription Pick Up Requests	☐ Prescription Pick Up Requests

By signing below I am acknowledging that I have read and understand all aspects of the above, and I am aware that:

- I have the right to refuse to sign this authorization form and I have the right to revoke this form at any time by submitting a Cancellation of Authorization Form to the front office staff.

_____ _____

Your signature (or Signature of Personal Representative*) Date Signed

**If you are acting as the Personal Representative of the individual whose PHI is to be disclosed, you must provide proof of your authority to act for that individual.*

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PATIENT RESPONSIBILITIES

(Updated 7/13/2018)

Patient Name: _____DOB: _____MRN: _____

Date: _____ Name accompanying patient: _____

Welcome to Family Medical Associates of Raleigh, your Patient Centered Medical Home (PCMH)! As a PCMH, we are committed to partnering with you to provide a medical home that is respectful, compassionate, accessible, and comprehensive. We are committed to working with you and your family to help you effectively manages your health. To ensure the best possible treatment and care management, we ask that you:

1) Read our Patient Centered Medical Home Brochure. It can be found on the website www.fmaraleigh.com or in brochure form in our office.
2) Provide as much information as possible about your health and medical history. This includes past and present illnesses, surgeries, medications (over the counter medications, herbal supplements and prescriptions), allergies, immunizations and family medical history.
3) Notify us whenever adding other professionals to your healthcare team.
4) Notify us as soon as possible whenever you have been in the hospital, been to the Emergency Room, or been seen in an Urgent Care Clinic.
5) Comply with any follow-up recommendations provided by your medical provider including follow up appointments, labs and referral recommendations.
6) Complete all diagnostic testing (labs, x-rays, etc.) in a timely fashion.
7) Request medication refills at least 48 hours before your medication refill expires.
8) Return to office at least every six months for a FACE TO FACE follow up visit with your medical provider if you take ANY maintenance or routine medications.
9) Notify your medical provider prior to stopping ANY medication prescribed.
10) Ask questions when you do not understand treatment recommendations and/or instructions.
11) Seek medical advice when appropriate.
12) Accept responsibility for your actions if you decline treatment or do not follow your medical provider's instructions and/or medical advice.
13) Understand your insurance policy - what benefits are covered or not covered.
14) Meet your financial obligations to Family Medical Associates of Raleigh (copays, co-insurance and service fees are due at time service is rendered).
15) Act in a manner that is respectful of other patients, our clinical support team, our administrative team, our schedulers and our clinic property.

Your health is important to us and by playing an active role in your medical care our providers will be able to provide the best care for you. Thank you for joining our Family Medical Associates of Raleigh team and we look forward to providing care for you and your family.

Patient or Guardian Signature:_____ Date:_____

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PATIENT REGISTRATION FORM

Welcome to Family Medical Associates of Raleigh! MRN: _____

PATIENT INFORMATION *Please complete this entire form, or notify our staff if you are unable to.*

Last Name: _____ First: _____ M.I. _____

D.O.B.____/____/_____SS#_____Gender:_____Race:_____

Primary Language: _____ Ethnicity: _____ Marital Status: _____

Mailing Address:_____Apt.#_____City: _____

State: _____ Zip: _____ DL State/#: _____ Home Phone _____

Work Phone_____ Cell Phone_____ Email _____

Preferred Method of Communication: ☐ Email ☐ Text ☐ Phone Call ☐ Mail

Physical Address, if different than your mailing address: _____ Apt. #_____

City: _____State: _____ Zip: _____

Pharmacy Name and Location: _____Pharmacy Phone #: _____

Spouse's Name and phone: _____ / _____

Emergency Contact and phone: _____ / _____

Employer Name: _____ Employer Phone #: _____

Employer Address: _____

RESPONSIBLE PARTY, IF NOT SELF (PARENT OR GUARDIAN)

Last Name: _____ First: _____ M.I. _____

D.O.B.____/____/_____SS#_____Gender:_____Race:_____

Mailing Address:_____Apt.#_____

City: _____ State: _____ Zip: _____ DL State/#: _____

INSURANCE INFORMATION (PLEASE PRESENT YOUR INSURANCE CARD WITH THIS FORM)

Primary Ins. _____ Policy Holder _____ D.O.B.____/____/____

Relationship: _____ Policy # _____ Group# _____

SS# _____Employer:_____

Secondary Ins. _____ Policy Holder_____ D.O.B. ____ /____/____

Relationship: _____ Policy # _____ Group# _____

SS# _____Employer: _____

Today's Date

_____

Family Medical Associates of Raleigh, PA

Patient Health Assessment Form V. 7/18

MR#_____

Provider_____

Name:_____ Date:_____ DOB:___/___/___(mm/dd/yyyy) Age:_____

Gender:_____ Birthplace:_____(City/State/Country) Race:_____ Ethnicity:_____

Preferred Language:_____ 2ndry Language:_____ Level of education:_____

Please check any that apply: ☐ Visually Impaired ☐ Glasses/Contacts ☐ Hearing Impaired ☐ Dentures

☐ Pacemaker ☐ Artificial Limbs ☐ Impaired Cognition ☐ Require an Interpreter ☐ Require Wheelchair Assistance

Please complete these questions every year

HEALTH SCREENING HISTORY: List the date of your most recent test or exam (if applicable).

Mammogram_____ Pap Smear_____ Eye Exam_____ Dental Exam_____ Breast Exam_____

Cholesterol Test_____ Blood Sugar_____ PSA_____ Other Blood tests (list)_____

EKG_____ Test for Blood in stool_____ Rectal Exam_____ Testicle Exam_____DEXA_____

Colonoscopy_____ Stress Test_____ Other testing_____

IMMUNIZATIONS: Tetanus_____ Hepatitis A_____ Hepatitis B_____ MMR_____ Flu_____

Pneumonia_____ Shingles_____ (If you are <18 years of age, please attach your childhood shot record)

SOCIAL AND LIFESTYLE HISTORY: Occupation:_____

Currently employed?_____ Military Service (Branch and length of service):_____

Relationship status: Married / Single / Divorced / Separated / Widowed / Significant Other

Living Arrangement: Alone / Family / Roommate / Significant Other / Homeless

Spouse's/Partner's Name:_____

Children (Names and Ages):_____

Number of sexual partners in last 12 months:____ Gender(s) of partner(s):____ Type of protection used:_____

Do you smoke cigarettes? Yes No If yes, how many? #_____packs per day _____years _____age started

Did you ever smoke? Yes No If yes, what age did you quit?_____ Are you exposed to secondhand smoke? Yes No

Do you drink alcohol? Yes No If yes, how much? _____drinks per week/day Type:_____

Do you use recreational drugs? Yes No If yes, which and how often?_____

Do you exercise regularly? Yes No If no, why, if yes what type?_____

Do you think your diet is healthy? Yes No If no, why not? _____

Do you have a written statement (advanced directive, living will) about your wishes for your medical care? Yes No

Over the past two weeks: have you felt down, depressed, or hopeless? Yes No

Have you had little interest or pleasure in doing things? Yes No

Over the past year, have you suffered significant financial hardship, loss of job, loss of health insurance? Yes No

Do you feel safe at home and in your personal relationships? Yes No

Would you like help with any questions you answered "Yes" to above? _____

What is the main reason for your visit today? _____

Do you have any other concerns we can address if time is available? _____

_____

Please list any other providers you see (specialists, physical therapy, etc) and date of last visit:

_____ _____

_____ _____

FOR WOMEN ONLY:

Have you started having periods? Yes No How old were you when they started? _____

Last Menstrual Period Date:_____ Method of Birth Control:_____

Pregnant? Yes No If yes, how many weeks____ Number of Pregnancies____ Number of Live Births_____

Established patients: please note any changes or new information since your last physical with our office below:

What symptoms or illnesses are you being treated for or have you been treated for in the past? Please list with date of onset. Ex: Diabetes, hypertension, kidney stones, cancer, HIV, Asthma, Cholesterol_____

_____

_____

Please list allergies and type of reaction to medications, foods, pets, bee stings, or other:

_____

_____

List all medications, vitamins and supplements you take, amounts, how often and why. *CIRCLE ANY REFILLS NEEDED*

_____ _____

_____ _____

List all prior hospitalizations, injuries, surgeries and dates they occurred.

_____ _____

_____ _____

PERSONAL AND FAMILY HISTORY: Check those that apply: (In Grandparents, list Mother's-MGM, MGF or Father's PGM, PGF)

	You	Mother	Father	Grandparents Paternal or maternal?	Sister/Brother	Children
Alcoholism						
Allergies						
Alzheimer's						
Anemia-type if known:_____						
Arthritis-type if known:_____						
Asthma						
Bleeding Disorder						
Breast Cancer						
Colon Cancer or Polyps-Which?_____						
COPD (emphysema)						
Depression/Anxiety or Bipolar						
Diabetes						
Drug abuse (recreational or prescription)						
Epilepsy or Seizures						
Glaucoma						
Gout						
Heart disease or attack-Age of onset:_____						
High Blood Pressure						
High Cholesterol						
HIV/AIDS						
Kidney Disease or failure						
Kidney Stones						
Liver Disease						
Melanoma						
Migraine Headaches						
Neurological Disorder-List type:_____						
Prostate Cancer						
Schizophrenia						
Stroke or TIA						
Thyroid Disorder						
Tuberculosis						
Other cancer not listed:_____						

FOR THIS SIDE ONLY: ☐ I have reviewed the questions above and there have been no changes since my last physical.

Patient or Guardian Signature:_____ Date:_____

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MEDICAL RECORDS RELEASE AUTHORIZATION

MRN: _____
Updated 07/19/2018

**** According to the NC statute (§ 90-411. Record copy fee.); there is a charge for medical records when requested for any reason except, "Referral to specialist". ProviderFlow has been contracted to provide this service and will invoice you directly.***

All fields are required and must be complete or this request may be rejected.

Patient Name: _____ DOB: _____/_____/_____

Mailing Address: _____City / State / Zip: _____

Daytime Phone: _____-_____-_____

Requesting records ***from*:** _____

Requesting records ***sent to*:** _____

Mailing address line 1: _____ Mailing address line 2:_____

City / State / Zip: _____ Phone: (_____) _____-_____ Fax: (_____) _____-_____

Purpose of request: □ □Referral to specialist □Insurance □Legal Investigation □Change of doctor □Personal

__I do __ I do NOT authorize release of information related to AIDS or HIV infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

Records Requested –Circle All That Apply

PROGRESS NOTES –** ***LAST THREE YEARS UNLESS OTHERWISE SPECIFIED BELOW*** **

HOSPITAL/ ER NOTES (DOS: _____) □□ EKG REPORTS □ PATHOLOGY REPORTS □ SURGICAL REPORTS

LAB RESULTS □ RADIOLOGY REPORTS (Site requested: _____)

Other _____

For the time period of: _____ to _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____
Signature of individual/guardian/legal representative **Date**

Office Use Only:

Received by: _____
Staff Signature (Witness) Date

Reviewed by Administration (local transfers only):_____
Signature Date

Processed by (ID verified): _____
Staff Signature Date

****Scan to Patient Chart****