

PRIMARY CARE / WALK-IN VISITS



Nancy Lynae Cheeks, FNP-C
Kati Whiteford, FNP-BC
Catherine Gordon FNP-C

Today Date: ___/___/___

PATIENT CONTACT INFORMATION

| | |
|---------------------------------------|--|
| Full Name | |
| Date of Birth | |
| Gender | |
| Phone Number | |
| Address | |
| Patient Email | |
| Emergency Contact Name & Phone Number | |
| Pharmacy | |
| Insurance | |

CONSENT

Having a condition requiring medical care, I hereby consent to rendering of such care, which may include diagnosis, care or treatment considered to be necessary, routine diagnostic procedures and such treatment by the attending provider who sees me. I understand that the provider at this facility is not affiliated with any particular hospital system.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize Hometown Healthcare to disclose my protected health and prescription information for treatment, payment and healthcare operations. This authorization would also include disclosure pertaining to the treatment of psychiatric, drug, alcohol, or abuse conditions, AIDS, AIDS-related conditions, HIV status or any other information protected by Federal or State statues. This information may be released to, but is not limited to, insurance companies known and unknown at the time services are provided, worker's compensation carriers and or employers responsible for payment of worker's compensation claims. Quality Improvement Organizations responsible for reviewing the medical care furnished by Hometown Healthcare and to the provider's rendering services to you such as: attending providers, radiologists, pathologists, emergency medical treatment providers, etc. All uses and disclosures of protected health information are more fully explained in the Privacy Notice. I understand that this authorization will remain in effect until revoked in writing. I understand that I may revoke this authorization by providing written notice to

- Hometown Healthcare. I understand that the revocation of the authorization will only apply to future disclosures of protected health information and will not include disclosures already honored prior to receipt of revocation.

ACKNOWLEDGEMENT OF NOTICE OF ADVANCED DIRECTIVES

Would you like a copy of the Advanced Directives brochure?

YES

NO

NOTICE OF PATIENT'S RIGHTS AND PRIVACY PRACTICES

Would you like a copy of the Patient's Rights and Responsibilities brochure?

YES

NO

Would you like a copy of the Hometown Healthcare's Notice of Privacy Practices?

YES

NO

PATIENT AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for HIPPA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.

I AUTHORIZE HOMETOWN HEALTHCARE TO RELEASE INFORMATION

REQUESTED TO THE FOLLOWING INDIVIDUALS:

NAME: _____

RELATIONSHIP: _____

NAME: _____

RELATIONSHIP: _____

NAME: _____

RELATIONSHIP: _____

ELECTRONIC PRESCRIPTIONS

I understand that Hometown Healthcare uses electronic prescribing. Prescriptions will be sent and medication history may be obtained electronically.

PATIENT INSURANCE CERTIFICATION

I certify that the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act is correct. I authorize release of all records required to act on this request. I request payment of authorized benefits be made on my behalf. ANY ORAL MEDICATION THAT CAN BE SELF-ADMINISTERED WHICH IS GIVEN TO ME IN THE OFFICE FOR OUTPATIENT TREATMENT WILL NOT BE PAID FOR BY MEDICARE OR SECONDARY INSURANCE INCLUDING MEDICAID AND BY SOME PRIVATE INSURANCES AND WILL BE BILLED TO THE PATIENT ACCORDINGLY.

PROMISE TO PAY

I understand that I am responsible, whether as patient or agent, to Hometown Healthcare for all charges incurred and not paid by third party benefits, and hereby guarantee payment of same together with previously incurred and yet unpaid medical charges. Should the account be referred to an Attorney or small claims court for collection, the undersigned shall pay reasonable attorney's fees and collection expense. I authorize Hometown Healthcare to obtain other credit information deemed necessary, including accessing my credit file to collect my unpaid charges.

SELF PAY

I understand and agree to pay \$97.50 upon day of service and will make payments of the remaining balance, if any.

OVERPAYMENTS

I authorize the refund of overpaid insurance benefits in accordance with my insurance policy provisions whereby coverages are subject to a coordination of benefits clause. I further authorize over payments due me be applied to any open accounts of myself or my dependents to Hometown Healthcare.

PATIENT PHOTOGRAPHS

I understand and accept photography at the time of registration for the purpose of identification through my medical treatment.

ACKNOWLEDGE OF PATIENT PAYMENT POLICES

I acknowledge that I have received a copy of Hometown Healthcare's Payment Policy. By signing below, I certify that I have read the above and understand Hometown Healthcare policies.

Patient's / Guardian Signature

Patient's Date of Birth

Relationship to Patient

| | | |
|--|--|--|
| | | |
|--|--|--|

HEALTH HISTORY

PLEASE CHECK ALL THAT APPLIES.

GENERAL

- CHILLS
- DEPRESSION
- FAINTING
- FEVER
- HEADACHE
- FORGETFULNESS
- NERVOUSNESS
- WEAKNESS
- SWEATS

GENITO- URINARY

- BLOOD IN URINE
- FREQUENT URINATION
- LACK OF BLADDER CONTROL
- PAINFUL URINATION

MEN ONLY

- BREAST LUMP
- ERECTION DIFFICULTIES (ED)
- LUMP IN TESTICLES
- PENIS DISCHARGE
- SORE ON PENIS
- OTHER _____

WOMEN ONLY

- VAGINAL DISCHARGE
- BLEEDING BETWEEN PERIODS
- BREAST LUMP
- EXTREME MENSTRUAL PAIN
- HOT FLASHES
- NIPPLE DISCHARGE
- ABNORMAL PAP SMEAR
- PAINFUL INTERCOURSE
- OTHER _____

SKIN

- BRUISE EASILY
- HIVES
- ITCHING
- CHANGE IN MOLES
- RASH
- SCARS
- SORE(S) THAT WON'T HEAL

CARDIOVASCULAR

- CHEST PAIN
- VARICOSE VEINS
- POOR CIRCULATION
- RAPID HEART RATE
- SWELLING OF ANKLES
- HIGH BLOOD PRESSURE
- LOW BLOOD PRESSURE

EAR/NOSE/THROAT

- BLEEDING GUMS
- BLURRED VISION
- CROSSED EYES
- DOUBLE VISION
- DIFFICULTY SWALLOWING
- EARACHE
- EAR DISCHARGE
- RINGING IN EARS
- HOARSENESS
- LOSS OF HEARING
- NOSEBLEEDS
- PERSISTENT COUGH
- HAY FEVER
- SINUS PROBLEMS
- VISION-HALOS
- VISION- FLASHES

GASTROINTESTINAL

- POOR APPETITE
- BLOATING
- BOWEL CHANGES
- CONSTIPATION
- DIARRHEA
- EXCESSIVE HUNGER
- EXCESSIVE THIRST
- GAS
- HEMORRHOIDS
- INDIGESTION
- NAUSEA
- RECTAL BLEEDING
- STOMACH PAIN
- VOMITNG

MUSCLE/JOINT/BONE

PAIN/WEAKNESS/NUMBNESS IN:

- ARMS
- BACK
- FEET
- HANDS
- HIPS
- LEGS
- NECK



PATIENT HEALTH HISTORY

CHECK CONDITIONS YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR:

| | | |
|--|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> PNEUMONIA |
| <input type="checkbox"/> ALCOHOLISM | <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> POLIO |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> GOITER | <input type="checkbox"/> PROSTATE PROBLEMS |
| <input type="checkbox"/> ANOREXIA | <input type="checkbox"/> GONORRHEA | <input type="checkbox"/> PSYCHIATRIC CARE |
| <input type="checkbox"/> APPENDIX | <input type="checkbox"/> GOUT | <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> SCARLET FEVER |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> BLEEDING DISORDERS | <input type="checkbox"/> HERNIA | <input type="checkbox"/> SUICIDE ATTEMPT(S) |
| <input type="checkbox"/> BREAST LUMP | <input type="checkbox"/> HERPES | <input type="checkbox"/> THYROID PROBLEM(S) |
| <input type="checkbox"/> BRONCHITIS | <input type="checkbox"/> HIGH CHOLESTEROL | <input type="checkbox"/> TONSILLITIS |
| <input type="checkbox"/> BULIMIA | <input type="checkbox"/> HIV POSITIVE | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> KIDNEY STONES | <input type="checkbox"/> TYPHOID FEVER |
| <input type="checkbox"/> CATARACTS | <input type="checkbox"/> LIVER DISEASE | <input type="checkbox"/> ULCERS |
| <input type="checkbox"/> CHEMICAL DEPENDENCY | <input type="checkbox"/> MEASLES | <input type="checkbox"/> VAGINAL INFECTIONS |
| <input type="checkbox"/> CHICKEN POX | <input type="checkbox"/> MIGRAINES/HEADACHES | <input type="checkbox"/> VENEREAL DISEASE |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> MISCARRIAGE | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> MONONUCLEOSIS | _____ |
| | <input type="checkbox"/> MUMPS | _____ |
| | <input type="checkbox"/> PACEMAKER | |

If you have had any surgeries list them below, with the surgery date if known:

Please list all known family history below and the family member(s) with that history:

Office use only:

Patient Status: Accept Decline

Provider Signature: _____

OFFICE AND FINANCIAL POLICIES



Nancy Lynae Cheeks, FNP-C
 Catherine Gordon, FNP-C
 Kati Whiteford, FNP-BC

Today Date: ___/___/___

HOMETOWN HEALTHCARE MISSION

“Our mission is to provide the highest standard of patient care with commitment to promoting health, wellbeing and disease prevention to all patients. We do not discriminate in the provision of excellent care and aim to treat all patients with dignity and respect.”

Thank you for choosing Hometown Healthcare for your health care needs. In an effort to make your transition to our practice as smooth as possible we have the following policies that we request you read and sign. Please feel free to seek clarification on any of our policies if you do not understand something.

Hometown Healthcare strives to provide our patients the highest level of customer service. Hometown Healthcare appreciates and welcomes your feedback to improve services or address any personal concerns regarding your medical care or office experience.

OFFICE HOURS

PRIMARY CARE

| | |
|-----------|-------------------|
| MONDAY | 8:00 AM – 5:00 PM |
| TUESDAY | 8:00 AM – 5:00 PM |
| WEDNESDAY | 8:00 AM – 5:00 PM |
| THURSDAY | 8:00 AM – 5:00 PM |
| FRIDAY | CLOSED |
| SATURDAY | CLOSED |
| SUNDAY | CLOSED |

WALK-IN VISIT

| | |
|-----------|--------------------|
| MONDAY | 8:00 AM – 5:00 PM |
| TUESDAY | 8:00 AM – 5:00 PM |
| WEDNESDAY | 8:00 AM – 5:00 PM |
| THURSDAY | 8:00 AM – 5:00 PM |
| FRIDAY | 8:00 AM – 12:00 PM |
| SATURDAY | CLOSED |
| SUNDAY | CLOSED |

THE OFFICE IS CLOSED 12 PM- 1 PM DAILY FOR LUNCH.

HOMETOWN HEALTHCARE IS CLOSED FOR ALL MAJOR HOLIDAYS:

- NEW YEARS DAY
- GOOD FRIDAY
- MEMORIAL DAY
- INDEPENDENCE DAY
- LABOR DAY
- VETERANS DAY
- THANKSGIVING DAY
- CHRISTMAS DAY

INSURANCE

- Insurance claims will be filed for you as a courtesy.
- If you have a deductible, which has not been met, or your insurance deems your visit as a non-covered service you will be responsible for the balance.
- The terms of your insurance policy are between you and your insurance company.
- All co-pays or deductibles will be paid beforehand.
- Patients with a large patient balance will be expected to pay at least 25% of the balance before the next appointment unless a payment plan has been made with our office.
- With all variations in insurance policies we ask that you please be familiar with the terms and policies of your insurance plan.
- All inaccuracies must be updated with your insurance before time of service.
- Any questions or problems with your insurance should be directed to your individual insurance company.
- Some insurance carriers require a primary doctor be selected and certain laboratories to process your lab specimens.
- You must notify our office staff of these restrictions.

FINANCIAL POLICY

- The patient is responsible for payment, co-payment, and deductibles at the time of service.
- Patients that are cash pay and pay their balance in full the day or service will receive a 25% discount.
- Cash pay patients must pay a minimum of \$97.50 on the day or service.
- Payments may be made for the remaining balance.

PAYMENT METHODS INCLUDE:

CASH
CHECK
VISA/MASTERCARD
AMERICAN EXPRESS
DISCOVER
INSURANCE ASSIGNMENT OF BENEFIT
MEDICARE
NC MEDICAID

WE DO NOT ACCEPT CARE CREDIT

APPOINTMENTS

Time is valuable for all of us and we want to give you and your health concerns our utmost attention. Therefore, if you arrive more than 15 minutes late for your appointment you may be asked to reschedule. We ask that you kindly give at least 24 hour notice when cancelling or rescheduling an appointment. Please call early in the day so we can accommodate your needs and we will make every effort to see you and your family on time and also ask for your understanding in the event we are running behind schedule as unforeseen emergencies and complex patients may warrant additional time in the office.

HEALTH FORMS AND RECORDS

We understand that health forms are required by many schools, employers and government agencies. We will be happy to fill out these forms during your appointment if that is the reason for the appointment. If a form is needed for a reason other than what is being addressed in your visit, a \$25.00 fee per form will be charged. Lengthy forms may have to be completed and picked up at a later time. Similarly, if a form completion is requested outside of an office visit it will be subject to a \$25.00 fee. Some forms may require an office visit for completion. In order to ensure accuracy and safety of your medical information all of our medical records are in digital format. Copies of your medical records are available to you with a signed medical record release.

IDENTIFICATION

All patients will need to bring their current drivers licenses or photo ID and an updated insurance card to each appointment. We depend on accurate information to file your insurance claim. Incorrect information can result in a denial of your claim.

PATIENT PHOTO

To ensure patient accuracy and identification we will be asked to have your picture taken for your record with us.

ADVANCED DIRECTIVES

Federal law requires that you be provided information about your rights to make advanced health care decisions, including a:

- Living Will
 - Durable Medical Power of Attorney
 - Designations Surrogate Decision Maker
- If you already have any of these documents, please inform Hometown Healthcare staff.
 - If you do not have an Advanced Directive and you would like information about this, please let clinical staff know and we will gladly provide you with information.

PATIENT DISMISSAL

We sincerely hope that we never have to part ways with a patient. However, extreme circumstances may make this necessary. If this occurs, you will be notified by mail. You will have 30 days to find another doctor during which we will continue to offer urgent care services only. Reason may include but are not limited to:

- Persistent Failure To Keep Scheduled Appointments
- Adhere To Agreed Upon Treatment Plans
- Repeated Failure To Pay Reasonable Medical Bills
- Ongoing Rude Or Disruptive Behavior
- Habitual Noncompliance
- Falsifying Or Providing Misleading Medical History
- Sentinel Incident (Verbal Threat, Violence, Criminal Activity)
- Conflict Of Interest

ANNUAL WELLNESS EXAMS

Office staff will schedule all new patient wellness exams after the initial office visit. Many insurance companies encourage such visits but will not pay for these visit until after you new patient visit. Wellness exams are to focus on health promotion activities, updating screenings and recommend vaccines. Please discuss your wellness benefits with your insurance company and notify our office if benefits are not available to you.

CONTROLLED SUBSTANCES

We do not provide chronic pain management services with controlled substances or narcotics; any chronic pain needs or other medical conditions requiring long – term controlled substances treatments will be referred to providers who can better manage your healthcare needs.

PRIVACY POLICY

I understand that, under the Health Insurance Portability and Accountalility Act of 1996 (HIPPA) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third party payers
- Conduct normal heathcare operations such as quality assessments and physical certifications.

POLICIES OF HOMETOWN HEALTHCARE

I have received, read and understand the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that *Hometown Healthcare* has the right to change its Notice of Privacy practices from time to time and that I may contact *Hometown Healthcare* at any time to obtain a current copy of Privacy Practices.

Having read the above, I agree to abide by the polices set forth by *Hometown Healthcare*. I realize that all charges incurred by me and my dependents are my financial responsibility. Failure to follow these polices could result in my dismissal as a patient. I also confirm that the information I have provided is true and correct.

Patient's / Guardian Signature

Patient's Date of Birth

**** Please sign below if you're the Responsible Party signing for a minor. ****

Patient's / Guardian Signature

Guardians Date of Birth

Relationship to Patient

Release of Medical Records

Hometown Healthcare



Nancy Lynae Cheeks, FNP-C
Kati Whiteford, FNP-BC

HOMETOWN HEALTHCARE RELEASE OF MEDICAL RECORDS REQUEST

Provider requesting medical records: [] Nancy Lynae Cheeks FNP -- C [] Catherine Gordon FNP - C [] Kati S. Whiteford FNP - BC
Fax Number 828-565-6182

Patient Name: _____ Date of Birth: _____
Release Records From: _____

Release All Records to: Hometown Healthcare

Purpose of Release: [] Continued patient care [] Request of individual/ personal [] Insurance [] Legal
Dates of treatment to be released: _____

Hospital (check all that apply):

- [] Hospital Summary [] Radiology Reports
[] Discharge Summary [] Pathology Reports
[] History & Physical [] ED Record
[] Consultation Reports [] EKG
[] Operative Reports [] Stress Test
[] Laboratory Reports [] Other: _____
[] Entire Record (not including psychotherapy notes)

Office/Clinic (check all that apply):

- [] Office/Clinic Summary
[] Office Visits
[] Physical Exam
[] Laboratory Reports
[] Radiology Reports
[] Other: _____
[] Entire Record (not including psychotherapy notes)

Delivery Method: [] Fax, where permitted [] Regular US Mail [] Overnight/Express Mail Service [] Pick Up

PATIENT/RESIDENT RIGHTS: I understand that:

- [] I can cancel this permission at any time. I must cancel in writing and send of deliver cancellation to releasing facility or practice name above. Any cancellation will apply only to information not yet released by facility or practice.
[] This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2, genetic information, HIV/AIDS, and other STDs).
[] Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.
[] Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in health plan, or eligibility for benefits. Hometown Healthcare will not share or use my health information without my permission other than by ways listed in Hometown Healthcare's Notice of Privacy Practices or as required by law.
[] A fee may be charged for providing the protected health information.
[] I have a right to receive a copy of this form upon request.

This permission expires one year after the date of my signature unless an earlier date or event is written here: _____

Signature: _____ Print Name: _____ Date: _____

If the patient/resident lacks legal capacity or is unable to sign, an authorized personal representative may sign this form. Note the relationship/authority is signature is not that of the patient. Written proof may be requested.

- [] Parent/Guardian [] Spouse
[] Healthcare Agent/POA [] Affidavit Next of Kin
[] Executor/Administrator/Attorney in Fact [] Other: _____

Hometown Healthcare Employee Name & Title: _____ Date & Time form faxed: _____