HOMETOWN HEALTHCARE

Nancy Lynae Cheeks, FNP-C

Office: 828-835-9571
Fax: 828-835-7217

Office Address:
163 Hwy 64 W, Suite 4
Hayesville, NC 28904

Mailing Address:
PO BOX 1020
Hayesville, NC 28904

## Hometown Healthcare Consent to Treat

Patient Name: _____ Date of Birth: _____

Patient Address: _____

**CONSENT TO TREAT:**
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 provider who sees me. I understand that the provider at *Hometown Healthcare* is not affiliated with any particular hospital system.

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:**
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 os psychiatric, drug, alcohol, or abuse conditions, AIDS, AIDS – realted 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, workers' compensation carries and or employers responsible for payment of workers' compensation claims. Quality Improvement Organizations responsible for reviewing the medical care furnished by Hometown Healthcare and to the providers' rendering services to you such as: attending providers, radiologists, pathologist, 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 wiriting 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 PATIENTS RIGHTS AND PRIVACY PRACTICES:**
Would you like a copy of the "Patient's Right and Responsibilities brochure? Yes No

Would you like a copy *of Hometown Healthcare's* "Notice of Privacy Practices"? Yes No

**Please list the names of persons we may speak to about your condition(s) or write none:**

_____ _____

_____ _____

*Please turn over to back side.*

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

**PATIENTS 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 MEDICATIONS THAT CAN BE SELF – ADMINISTERED WHICH IS GIVEN TO ME IN THE OFFICE FOR OUTPATIENT TREATM WILL BE PAID FOR BY MEDICARE OR SECONDARY INSURANCE INCLUDING MEDICAID AND BY SOME PROVATE INSURANCE 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 changes 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 (CASH) PATIENTS:**
I understand and agree to pay $97.50 upon day or service and will make payments of the remaining balance, if any.

**OVERPAYMENTS:**
I authorize he refund of overpaid insuance benefits in accordance with my insurance policy provision whereby coverages are subject to a coordination of benefits clause. I further authorize over payments due me to 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 POLICIES:**
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 / Guardian Signature:

_____

Date of Birth of patient or responsible party:

_____

Relationship to Patient:

_____

Date:

_____

HOMETOWN HEALTHCARE

Nancy Lynae Cheeks, FNP-C

Office: 828-835-9571
Fax: 828-835-7217

Office Address:
163 Hwy 64 W, Suite 4
Hayesville, NC 28904

Mailing Address:
PO BOX 1020
Hayesville, NC 28904

## Office and Financial Polices of Hometown Healthcare

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 clairfication 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* apperciates and welcomes your feedback to improve services or address any personal concerns reguarding your medical care or office experience.

**Our 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.

### *HOMETOWN HEALTHCARE OFFICE HOURS:*

*Monday – Thursday: 8:00 AM to 5:00 PM*
*Friday: Closed*
*Closed for lunch daily from 12:00 PM to 1:00 PM*
**Please note Hometown Healthcare is closed for all major holidays.**

**Insurance:** Insurance claims will be filed for you as a courtest. 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-poys 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 you individual insurance company. Some insurance carries require a primary doctor be selected and certain laboratories to process your lab specimens. You must notifiy our office staff of these restrictions.

**Financial Policy:** The patient is responsible for payment, co-payment, and deductibles at the time of service.

Payment methods include:

- Cash, Check, Visa / Mastercard, American Express, Discover
- Insurance Assignment of benefit
- Medicare and Medicaid

** Please note, we do not take CareCredit.**

**Cash Pay Patients:** Patients that are cash pay and pay their balance in full the day or service will receive a 25% discount. Please note, cash pay patients must pay a minimun of $97.50 on the day or service. Payments may be made for the remaining balance.

**Appointments:** Time is valuable for all of us and we want to giv 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 appoinment. We will take walk in sick visits as long as our schedule allows. 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 beind 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 appoinment. If a form is needed for a reason other that 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 licenes or photo ID and an updated insurance care 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 or 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 dys 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 or 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 activiy)
- 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 notifiy our office if benefits are not available to you.

**Contolled 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.

I have recevied, read and understand the Notice of Privacy Practices containing a more conplete description of the uses and disclosers 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 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 / Guardian Signature:

_____

Date of Birth of patient or responsible party:

_____

Relationship to Patient:

_____

Date:

_____

HOMETOWN HEALTHCARE

Nancy Lynae Cheeks, FNP-C

Office: 828-835-9571
Fax: 828-835-7217

Office Address:
163 Hwy 64 W, Suite 4
Hayesville, NC 28904

Mailing Address:
PO BOX 1020
Hayesville, NC 28904

## HOMETOWN HEALTHCARE RELEASE OF MEDICAL RECORDS REQUEST

**Patient Name:** _____ **Date of Birth:** _____

**Release Records from:** _____

**Release 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
☐ Discharge Summary
☐ History & Physical
☐ Consultation Reports
☐ Operative Reports
☐ Laboratory Reports
☐ Radiology Reports
☐ Pathology Reports
☐ ED Record
☐ EKG
☐ Stress Test
☐ 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
☐ Healthcare Agent/POA
☐ Executor/Administrator/Attorney in Fact
☐ Spouse
☐ Affidavit Next of Kin
☐ Other: _____

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

HOMETOWN HEALTHCARE

Office: 828-835-9571
Fax: 828-835-7217

Office Address:
163 Hwy 64 W, Suite 4
Hayesville, NC 28904

Mailing Address:
PO BOX 1020
Hayesville, NC 28904

Patient Name: _____ Date of Birth: _____

Previous Doctor / Provider: _____

Best phone number: _____

Today's Date: _____ Date of last physical exam: _____

**General:**
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Headache
- ☐ Forgetfulness
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Weakness
- ☐ Sweats

**Gastrointestinal:**
- ☐ Poor appetite
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach pain
- ☐ Vomiting

**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

**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 _____

**Muscle/Joint/Bone:**
Pain/weakness/numbness in
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck

**Cardiovascular:**
- ☐ Chest Pain
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart rate
- ☐ Swelling of ankles
- ☐ Varicose veins

**Skin:**
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore(s) that won't heal

**Genito – Urinary:**
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

## Check conditions you currently have or have had in the past year

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendix
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical dependency
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV positive
- ☐ Kidney stones
- ☐ Liver disease
- ☐ Measles
- ☐ Migraines/headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate problem(s)
- ☐ Psychiatric care
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Suicide attempt(s)
- ☐ Thyroid problem(s)
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Vaginal infections
- ☐ Venereal disease
- ☐ Other _____

**Medication list:** ***if you need additional space, please write them on a separate piece of paper***

| Prescription Name: | Dosage (mg, mcg, units, etc.): | Directions (how you take the prescription): |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**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:*

Return intake received by: _____ Date intake received: _____

Provider Signature: _____ Date: _____

Patient Status: Accept ☐ Decline ☐