# ASPIRE2HEALTH PA

2298A US 70 Hwy Swannanoa, NC 28778
*phone* 828-686-5232 *fax* 828-686-7269 *after hours* 828-251-4874
**www.aspire2health.com**

# NEW PATIENT REGISTRATION

Underlined fields are **REQUIRED**

## PATIENT INFORMATION

| | | |
|---|---|---|
| **Today's Date:** | **Last Name:** | **First Name:** |
| Preferred Name: | Middle Name: | Suffix: |
| **Date of Birth:** | **Sex:** Male Female | SSN: |
| Marital Status: Married Single Divorced Separated Widowed Partner | Emergency Contact: | |
| | Relationship: | Phone: |
| Guardian Full Name (**required for minors**): | | |
| How did you hear about us? | | |

## DEMOGRAPHIC INFORMATION (optional)

| | |
|---|---|
| Language: | Ethnicity: Hispanic or Latino Not Hispanic or Latino |
| Race: American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander White | |

## CONTACT INFORMATION

| | | |
|---|---|---|
| **Address:** [Street/PO Box, City, State, Zip] | | |
| **Home Phone:** | Mobile Phone:<br>Same as Home? [ ] | Work Phone: |
| **Email:**<br>No email? [ ] | **Contact Preference:** Home Phone Mobile Phone Work Phone Mail Portal | |

## GUARANTOR INFORMATION (**required for minors**)

This is where statements are sent. This section is not required if statements should be sent to the patient at the above address.

| | | |
|---|---|---|
| **Last Name:** | **First Name:** | **Date of Birth:** |
| SSN: | **Phone:** | Email: |
| **Address:** [Street/PO Box, City, State, Zip]<br>Same as Patient's above? [ ] | | |

## PRIOR TO PROCESSING YOUR REGISTRATION YOU MUST SUBMIT A VALID PHOTO ID AND INSURANCE CARD(S)

Insurance cards received Photo ID received Patient approved New Appointment Date ________________

FOR OFFICE USE ONLY New Appointment Time ________________

All items completed

# ASPIRE2HEALTH PA

## Health History

| Present Complaint | |
|---|---|
| Please list any drug allergies | |
| Please list any surgeries & hospitalizations that you have had | Dates |
| | |
| | |
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| | |
| | |

| Women's Health | | Men's Health |
|---|---|---|
| # of pregnancies | Last pap smear | Last complete physical exam |
| # of births | Last breast exam | Last prostate exam |
| Have you reached menopause?<br>NO YES | Last mammogram | Last PSA (blood test for prostate disease) |
| Do you have any of the following menopausal symptoms?<br>Sleep disruption<br>Fatigue | Vaginal dryness<br>Hot flashes<br>Irritability<br>vaginal dryness | **TRAUMA, both sexes**<br>Fractured bones<br><br>Car accidents |
| Hysterectomy NO YES if yes complete partial<br>If no Last Menstrual period | | Other Concerns |

### MAINTENANCE & PREVENTION: Please check any done and give date of last study

| | | | |
|---|---|---|---|
| EKG | Date: | Rectal Exam for Blood | Date: |
| Chest X-Ray | Date: | Colonoscopy | Date: |
| Blood Panel | Date: | Pneumonia Vaccine | Date: |
| Cholesterol Level | Date: | Tuberculin Skin Test | Date: |
| Thyroid Profile | Date: | Tetanus Booster | Date: |
| Homocysteine Level | Date: | Bone Density | Date: |
| Flu Shot | Date: | ____________________ | Date: |

Please describe your present REGULAR EXERCISE routine such as walking, swimming, weight training, hiking, etc:

NONE ______________________________________________________________

## Social History

| | | | |
|---|---|---|---|
| Coffee No Yes, Amount | Tea No Yes, Amount | Tobacco No Yes<br>packs per day | # of years |
| Caffeinated Soda No Yes, Amount | Any other drug history No Yes, explain | | |
| Alcohol No Yes | Beer<br>Amount per week | Wine<br>Amount per week | Liquor<br>Amount per week |
| Ever been convicted of a felony? | | | |

# ASPIRE2HEALTH PA

## Family Health History

| | | | |
|---|---|---|---|
| **MOTHER**<br>Living Age | Health Problems | | |
| Deceased At age | Cause of death | | |
| **FATHER**<br>Living Age | Health Problems | | |
| Deceased At age | Cause of death | | |
| **SISTERS** | How many? | How many Living? | Ages? |
| General health among sisters | | | |
| **BROTHERS** | How many? | How many Living? | Ages? |
| General health among brothers | | | |
| **MATERNAL GRANDMOTHER**<br>Living Age | Health Problems | | |
| Deceased At age | Cause of death | | |
| **MATERNAL GRANDFATHER**<br>Living Age | Health Problems | | |
| Deceased At age | Cause of death | | |
| **PATERNAL GRANDMOTHER**<br>Living Age | Health Problems | | |
| Deceased At age | Cause of death | | |
| **PATERNAL GRANDFATHER**<br>Living Age | Health Problems | | |
| Deceased At age | Cause of death | | |
| FAMILY HEALTH HISTORY NOT KNOWN | | | |

## Medications

**PLEASE LIST ANY MEDICINE(S) YOU ARE CURRENTLY TAKING**

| MEDICATIONS | DOSAGE | PRESCRIBING DR | PHARMACY |
|---|---|---|---|
| | | | |
| | | | |
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# ASPIRE2HEALTH PA

# Policies and Procedures

Thank you for choosing us as your health care provider. We are committed to providing you with high quality and affordable healthcare. The following is a statement of our Office and Financial Policies and Procedures. Your signature is required prior to any treatment and indicates you understand these policies. A copy of these policies will be provided at your request. Additionally:

- All patients must complete our information and insurance forms before treatment.
- For your convenience we accept cash, check, Visa, and MasterCard.

## Office Policy and Procedure

*Office Hours:* Monday-Thursday 8:30 am to 4:30 pm, Friday 10:00 am to 3:00 pm. Phone messages may be left after these hours and will be addressed the next business day. Please call during inclement weather as our hours may vary.

*Medical Emergencies:* **Should you experience chest pain, dial 911.** For afterhours emergencies go to an Urgent Care Center or the Hospital. Please note that prescription refills and referrals are not medical emergencies. For other non-emergency after-hours needs, call the after-hours number listed above.

*Prescriptions:* **Lost or stolen controlled substance prescriptions will not be replaced.** All prescription bottles must be brought to each visit in order to provide you with refills needed and to avoid fees for in-between visit refills. **Call your pharmacy to request refills.** We require up to 72 business hours to complete a refill request once received from your pharmacy. **Refills will not be called in after hours or on weekends.**

*Missed Appointments:* Notification is required **at least 24 business hours in advance** to cancel appointments. Cancelling in advance allows for other patients to be seen if needed. Repeated missed appointments may result in a walk-in only status. Walk-in appointments are taken depending on availability. Missed appointments due to inclement weather will not be charged.

*Referrals:* When necessary, a referral may be made for a condition(s) that you have been treated for in our office to other physicians or diagnostic. Please allow 3-5 business days for your referral to process. Generally, you will receive a call from the referral location to set up an appointment.

*Test Results:* Test results are reviewed with our patients at their regularly scheduled office visits. For critical conditions we will contact the patient immediately once reviewed by the physician.

*Medical Records:* Please allow up to 10 business days to process records requests. Our office charges fees for the copying of medical records at the rate allowable under North Carolina state law.

# ASPIRE2HEALTH PA

## Financial Policy

Please understand that payment of your bill is considered a part of your treatment. Payment for services are due at the time of service. If you have insurance, please verify that we are in network with your insurance company prior to receiving treatment.

*In Network Insurance Plans:* All co-pays and deductibles are due at the time of treatment. If there are any additional procedures performed, they may be subject to an additional **Co-Payment, Deductible or Co-Insurance.**

*Non-covered Services:* Please be aware that some insurance companies may determine treatment to be non-covered or find it not to be reasonable or necessary. If such a determination is made, you will be responsible for payment of such services.

*Outstanding Insurance Balances:* Unpaid insurance balances are the patient's responsibility after 60 days. Payment is expected upon receipt of statement.

*Outstanding Patient Balances:* Unpaid balances are required to be paid prior to scheduling further appointments. Exceptions *may* be made in the event of an emergency. We will work with patients who are experiencing financial hardship if they are willing to make an effort to take care of their balance. Otherwise, patient balances over 120 days will be turned over to an outside collection agency. If your account is sent to collections, you will be responsible for all fees and costs associated with collecting the balance. You must contact the collection agency to resolve this balance.

*Minor Patients:* Parents or guardians of minors are responsible for payment of services and must accompany minors for treatment except in emergencies or conditions allowed by North Carolina state law.

*Administrative Fees:*

- Rescheduling Fee: For appointments not cancelled or rescheduled in a timely manner, a **$30.00** fee must be paid prior to rescheduling the missed appointment.
- Prescription Refill Fee: For prescriptions refills in between office visits there is a **$10.00** fee.
- Same Day Refill Fee: For prescriptions needing refills the same day they are requested there is a **$15.00** fee.
- Form Completion Fee: Our office charges a fee for the completion of forms. These charges will be your responsibility and must be paid prior to completion and allowed 2 weeks to complete.
- Insufficient Funds Fee: There is a **$25.00** fee for any checks returned due to insufficient funds.

Thank you for understanding our ***Policies and Procedures***. Please let us know if you have any questions or concerns.

**I have read the *Policies and Procedures* and I understand and agree to its provisions.**

______________________________________ ________________________

**Signature of patient or responsible party** **Date**

# ASPIRE2HEALTH PA
# Patient Consent Form

**Patient Consent for Use and Disclosure of Protected Health Information**

I hereby give my consent for **ASPIRE2HEALTH PA** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

(The Notice of Privacy Practices provided by **ASPIRE2HEALTH PA** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **ASPIRE2HEALTH PA** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Janey Kelly, 2298 US HWY 70 Unit A, Swannanoa, NC 28778.**

With this consent, **ASPIRE2HEALTH PA** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **ASPIRE2HEALTH PA** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **ASPIRE2HEALTH PA** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **ASPIRE2HEALTH PA** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **ASPIRE2HEALTH PA** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **ASPIRE2HEALTH PA** may decline to provide treatment to me.

_________________________________
Signature of Patient or Legal Guardian

_________________________________ _______________________
Print Patient's Name Date

_________________________________
Print Name of Patient or Legal Guardian if Applicable

# ASPIRE2HEALTH PA
# Assignment of Benefits

## FINANCIAL RESPONSIBILITY

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

## ASSIGNMENT OF BENEFITS

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to ASPIRE2HEALTH PA, formerly Swannanoa Valley Family Medicine PA, for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

## AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize ASPIRE2HEALTH PA to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from ASPIRE2HEALTH PA on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

____________________________________
Signature of Patient or Legal Guardian

____________________________________ _________________________
Print Patient's Name Date

____________________________________
Print Name of Patient or Legal Guardian if Applicable