PALLADIUM PRIMARY CARE

2510 W Gate City Blvd

GREENSBORO, NC 27403

336-841-8500

336-841-3999

PATIENT HEALTH HISTORY

Patient Name_____ Date_____

Age_____ Date of Birth_____ Date of Last Physical_____

What is the reason for this visit? _____

CHECK SYMPTOMS YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR

CONSTITUTIONAL	**CARDIOLOGY**	**RESPIRATORY**	**PSYCHOLOGY**	**ALLERGY**
Fever	Chest Pain	Shortness of Breath	Depression	Itchy Eyes
Chills	Palpitations	Shortness of Breath	Anxiety	Sneezing
Weight Loss	Leg Edema	with Exercise	Stress	
Loss of Appetite	Shortness of Breath	Persistent Cough	Suicidal Notions	
Fatigue	while laying down	Wheezing		
	Shortness of Breath	Coughing up Blood		
	when awoken from sleep			

GASTROENTEROLOGY	**NEUROLOGY**	**ENDOCRINOLOGY**	**UROLOGY**
Abdominal Pain	Headache	Urinary Infrequency	Painful Urination
Nausea	Weakness	Excessive Thirst	Difficulty Urinating
Vomiting	Tingling/Numbness	Cold Intolerance	Urinary Frequency
Heartburn	Speech Abnormality	Heat Intolerance	Urinary Urgency
Difficulty Swallowing	Visual Changes		Blood in Urine
Diarrhea	Dizziness		

DERMATOLOGY	**ENT**
Rash	Change in Voice
Hives	Snoring
	Ear Pain
	Rhinorrhea
	Sore Throat

LIST MEDICATIONS YOU ARE CURRENTLY TAKING:

_____

_____

_____

_____

ALLERGIES:

_____

_____

_____

_____

PAST MEDICAL HISTORY

Surgeries:

_____

_____

_____

_____

FAMILY HISTORY:

Father: _____

Mother: _____

Siblings: _____

SOCIAL HISTORY:

Tobacco Use: Yes No Packs per Day: _____

Alcohol Use: Yes No Drinks per Day: _____

DATES OF MOST RECENT VACCINATIONS:

Hepatitis A _____ Hepatitis B _____

Flu Shot _____ Pneumonia Shot _____ Tetanus Shot _____

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336-841-8500 (Phone)

336-841-3999 (Fax)

Patient Information

Patient Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ SS#: _____ Sex: _____

Home Telephone: _____ Work Telephone: _____ Cell Telephone: _____

Married: _____ Single: _____ Divorced: _____ Widowed: _____

Employer Information

Employer: _____

Address: _____

Insured Information

Name: _____

Address: _____

Date of Birth: _____ SS#: _____ Sex: _____

Insurance Information

Primary Insurance _____ Secondary Insurance _____

Address _____

Subscriber Id#_____

Group_____

Pharmacy

Name_____

Address_____

Phone_____

Emergency Contact

Name_____ Relationship_____

Address_____Telephone_____

The undersigned hereby authorizes said Provide(s) to release all information pertaining to the patient's treatment to his/her insurance company or companies and to any other physician or health care provider to whom the undersigned may be referred. I hereby assign all medical and or surgical benefits, to which I am entitled, including medical, private Insurance, and other Health Plans to Palladium Primary Care.

Sign_____ Date_____

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IF YOU ARE HERE FOR A ROUTINE ANNUAL OR WELL VISIT PLEASE LET US KNOW

Most Insurances will not allow you to combine a routine annual and problem visit. This means you cannot discuss problems or ask for medical advice during a routine well visit. Doing so may cause your insurance to deny payment for the whole visit and you will be responsible for the bill.

PLEASE CHECK ONE:

_____I am having a routine annual or well visit and I will not discuss medical concerns or request medical advice.

_____I am having a problem or concern I would like to discuss with the doctor. I will reschedule my routine annual exam.

_____I want to have my annual exam and I have a medical problem/concern evaluated today. I accept responsibility for my bill.

Sign_____ Date _____

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OFFICE POLICIES

Thank you for choosing Palladium Primary Care for your medical care services. Our office strives to provide excellent medical care for the patients. Please ready carefully, sign and date the office policies.

UPFRONT COLLECTION

Your copay will be collected upfront by the front desk receptionist / cashier at the time of service before your service being rendered.

There will be a percentage collected upfront on your deductible amount that has not been met according to your Insurance Benefits calendar year.

Your Co-Insurance amount will be collected at the time of service according to your Insurance Benefits.

Our office will provide a sliding scale fee for all Self Pay patients, this fee will be collected at the time of service is rendered.

INSURANCE CARD AND IDENTIFICATION CARD

Your Insurance Card and Identification Card (Driver's License) will be required at the time of your appointment. If you do not have your insurance card or ID Card your appointment will be rescheduled to when you can provide this information to us.

INSURANCE FILING

Your office visit will be filed to your insurance company

LABCORP

The above company will be performing your Clinical Laboratory and Pathology tests. These charges are not included in the fee charged by our Physician. You will receive a document called an Explanation of Benefits. IT IS NOT A BILL, you do not have to send a payment. Read the document carefully as different insurance companies label their document differently.

Please keep in mind, per your policy; you may be personally responsible for any appropriate co-payments, deductible, or non-covered charges. The copay/deductible for your doctor's visit does not include laboratory services.

Should you have any questions please call: LABCORP BILLING DEPARTMENT at 1-888-742-7234

Signed_____ Date_____

STANDARD HIPPA RESTRICTIONS

HIPPA (Health Insurance Portability Act of 1966) - A Federal Law which protects and enhances the right of patients by giving them to access to their personal health information and more control over its use.

Directions: If you would like to choose a restriction, INITIAL the item on the left side and SIGN AT THE BOTTOM of the form. Please be sure you understand what the restriction means before choosing it. PLEASE DESCRIBE YOUR REQUEST AS CAREFULLY AS POSSIBLE IN THE SPACE PROVIDED. Please realize that if you request other restrictions do not begin unless and until approved by the Privacy Officer. Once in place, any restriction will remain in effect until such time that you change it. New restrictions will replace any restrictions that you have made in the past.

a. Hospital Directory: If you do not want anyone to receive any information about you including that you are a patient, your location or condition, please initial below that you do not want to be in the directory. If you do not want your general condition and/or religion included in the directory, initial your choice below.

_____ No Directory. No one will know you are a patient, your room number, condition or religion.

_____ In Directory, do not release general condition.

_____ In Directory, do not release religion.

b. Individuals Involved In Your Care: We may disclose information about you to a friend or family member who is involved in your medical care, unless you object. If you object, indicate your choice here.

Please describe: _____

c. Appointment Reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at PPC. We may leave a message for you at any telephone number or email address you give us stating the date, time and location of the appointment. If you want to handle reminders differently, suggest an alternate method here.

Please describe: _____

d. Request for Alternative Type of Communication: You may request that we communicate with you about medical matters in a certain way or at a certain location. If you want to make this request, indicate your choice here. You must specify how or where you wish to be contacted. We will not ask you the reason for your request. We will accommodate all reasonable requests. We will let you know if we can accommodate your particular request.

Please describe: _____

e. Disaster Relief Purpose: If a disaster occurs, we will use our professional judgment to decide whether it is in your best interest to disclose information to someone who is involved in your care to an agency assisting in a disaster relief effort. If you do not want anyone to know this information about you, if you want to limit the amount of information that is disclosed, or if you want to limit who gets the information, indicate your choice here.

Please describe: _____

f. Other Restrictions Requested:

Please describe: _____

g. Restrictions Approved by Privacy Officer:

Please describe: _____

h. Restrictions Not Approved by Privacy Officer:

Please describe:_____

REMOVAL / CHANGE OF RESTRICTION

_____a. Removal (Specify Restriction to be removed)_____

_____b. Change of Restriction (Specify how Restrictions will be changed)_____

I understand that this consent/authorization will automatically expire three years. I also understand that I may revoke or discontinue my consent/authorization at any time by notifying PPC writing, except to the extent actions have already been taken based upon my consent/authorization, including the disclosure of information to third party payers to seek payment for the care treatment provided to me. Any revocation will be effective one business day after written revocation is received by the Privacy Officer of PPC. I understand and agree to the above releases, authorizations and assignments of benefits.

Signature:_____Date:_____

(Patient or legal guardian/closet available relative/authorizes representative, if patient is unable to sign)

Signature:_____Date:_____

Receipt of Notice of Privacy Practices:

I certify that I have been offered and/or received a copy of the PPC Notice of Privacy Procedures:

Signature:_____Date:_____

Consent to Diagnosis and Treatment Obtain by Telephone

Treatment/Procedure:_____

_____

Authorized Person Giving Consent:

Name:_____Date:_____

Relationship to the Patient:_____

Telephone:_____

Witness:_____

I authorize the following persons to receive my protected health information:

_____

Authorization to leave messages on alternate phone number:

_____

_____

Staff Use Only: Notice of Privacy Practices

O Patient unable to sign due to condition and or level consciousness

O Patient refused to sign after being offered Privacy and Consent Form

O Other

Completed By:_____Date:_____

APPOINTMENT RESPONSIBILITY OF PATIENTS

To better serve our patients needs and serve them with the best customer service, we want to make every effort to see our clients promptly at the appointment time. In addition, most of us don't like to have to wait for an appointment time or wait for an appointment to see their Physician or be put on a waiting list, when the need is great to be seen as soon as possible. Unfortunately, some of our clients either do not show for their scheduled appointment is scheduled to call and cancel. If you do not come in for your appointment, valuable time is lost.

1. In return for our promptness with you, we ask that you be just as responsible for keeping appointments on time. If you are late, your visit will be shorter in length or cancelled, as another patient is usually waiting.

2. In case of appointments not kept or cancelled less than 24hrs in advanced, you are advised there will be a charge of $50. This is a non-covered service under your Insurance Plan.

3. We realize that occasionally there may be an emergency which prevents you from making your appointment. We expect a phone call from you as soon as possible to notify us. However, if this occurs with frequency, we will need to refer you to other Health resources in the community.

I have read and understand the conditions of this agreement. By my signature, I acknowledge I will be financially responsible for payment for missing the appointment and/or late cancellation of less than 24hrs in advance. The payment must be made before the next appointment will be scheduled.

Patient Signature_____ Date_____

PALLADIUM PRIMARY CARE

Meaningful Use became one of the most frequently used terms in the healthcare industry in 2009. The Adoption of Meaning use is focused on health care professionals using certified electronic records (EHR) technology to improve health outcomes in the following areas:

- Improve the quality of care, efficiencies and safety in treating patients
- Reduce Health Disparities
- Engage patients and families
- Improve care coordination
- Improve population and public health
- Guarantee adequate privacy and security protection of PHI (patient health information)

We would like you to give us the following information to help us meet the goals of Meaningful Use

Name_____

E-Mail Address_____

Ethnicity_____

Race_____

Language_____

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CONSENT FOR RELEASE OF MEDICAL RECORDS

Patient Name_____

Date of Birth_____

I do here consent and authorize you to release copies of any medical records, including current and previous medical records from other practices and practitioners, hospitals, and/clinics which are part of my medical records. PLEASE NOTE: This authorization includes consent for the release of alcohol, drug, psychiatric and psychological information and any information related to HIV testing, AIDS and AIDS related syndrome, which may include in my records. It may also include information concerning cancer, cancer testing and cancer results. I agree that a copy of this release shall be as valid original.

Is this a permanent transfer: _____

Records to be sent to:_____

Provider Name: _____

Address: _____

Phone Number: _____

Fax Number: _____

Patient Signature: _____

Date: _____

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