# BURLINGTON Family PRACTICE

## Patient Demographic Information

**Please PRINT**

**MRN** **Date**

### PATIENT INFORMATION

Last Name | First Name | Middle Initial | Nickname/AKA

Date of Birth | Social Security Number | Gender ❑ Male ❑ Female

Marital Status ❑ Married ❑ Single ❑ Divorced ❑ Life Partner ❑ Separated ❑ Widowed ❑ Other ❑ Preferred language other than English

Race (Optional) ❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American ❑ More than one race ❑ Native Hawaiian ❑ Other Pacific Islander ❑ Refused to Report/ Unreported ❑ Undefined ❑ White

Ethnicity (Optional) ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Refused to Report/Unreported ❑ Undefined

Home Address | Apt # | City | State | Zip Code

Home Phone | Work Phone | Other Phone ❑ Cell ❑ Pager ❑ Fax

Email Address | Employment Status ❑ Active Duty Military ❑ Civil ❑ Disabled ❑ Employed Full Time ❑ Employed Part Time ❑ Homemaker ❑ Not Employed ❑ Retired ❑ Self Employed ❑ Student Full Time ❑ Student part Time ❑ Other

Employer

### PHYSICIAN REFERRAL INFORMATION

Primary Care Physician

How did you hear about us? ❑ Billboard ❑ Employer ❑ Family Member ❑ Friend ❑ Health Fair Event ❑ Insurance ❑ Magazine ❑ Mail ❑ News ❑ Website ❑ Yellow Pages ❑ Other

### RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient ❑ Self (If Self, skip to Emergency / Next of Kin) ❑ Spouse ❑ Parent ❑ Other

Last Name | First Name | Middle Initial

Date of Birth | Social Security Number

Home Address | Apt # | City | State | Zip Code

Home Phone | Work Phone | Other Phone ❑ Cell ❑ Pager ❑ Fax

Employer | Employment Status ❑ Active Duty Military ❑ Civil ❑ Disabled ❑ Employed Full Time ❑ Employed Part Time ❑ Homemaker ❑ Not Employed ❑ Retired ❑ Self Employed ❑ Student Full Time ❑ Student part Time ❑ Other

Employer Phone

### EMERGERNCY / NEXT OF KIN CONTACT INFORMATION

Last Name | First Name | Relationship to Patient

Address | Apt# | City | State | Zip Code

Home Phone | Work Phone | Other Phone ❑ Cell ❑ Pager ❑ Fax

### OTHER CONTACT INFORMATION – NOT LIVING WITH PATIENT

Last Name | First Name | Relationship to Patient

Address | Apt# | City | State | Zip Code

Home Phone | Work Phone | Other Phone ❑ Cell ❑ Pager ❑ Fax

Alamance Regional
Physicians Care

FINANCIAL POLICY
Alamance Regional Physicians Care

ACCT#:

DOB:

Burlington Family Practice
1041 Kirkpatrick Road, #200
Burlington, NC 27215-8066

**Your Responsibility**
You are financially responsible for the services ARMC Physicians Care, Inc. provides to you. We understand that many patients have insurance companies that cover a large portion of medical claims. However, the patient (or legal guardian if the patient is a child) is ultimately responsible for the bill if the insurance company does not pay.

As a courtesy to you, we will file a claim to your primary and secondary insurance plans. We do expect payment of co-payments and payment for services not covered by insurance plans at the time of service. Any balance remaining after insurance has paid their part of the covered portion will be due upon receipt of a bill (e.g. Coinsurance, Deductible, non-covered, etc.). If you are unable to pay the balance or need to discuss a payment plan, please contact us immediately to discuss your options.

**Patients Without Insurance**
ARMC Physicians Care Inc. is pleased to be able to provide services to patients that do not have insurance. If you do not have insurance, you will be required to pay $50 at the time of service and then you will receive a bill for the balance at a reduced rate that must be paid within 45 days. If you are unable to pay the balance, please contact us immediately to discuss your options.

**Medicare Patients**
ARMC Physicians Care, Inc. accepts Medicare assignment and we will bill your secondary insurance if you provide us the proper insurance information. You are responsible for the applicable coinsurance and deductibles, and charges for non-covered services.

**Medicaid Patients**
ARMC Physicians Care, Inc. accepts Medicaid assignment. A current Medicaid card must be presented at each visit and you will be required to pay the co-pay at the time of service. If you have exceeded the legislative limits for the year as set forth by Medicaid, you will be held responsible for the charges. If you have "Carolina Access" please be sure to bring your referral from your Primary Care Physician/Facility.

**Private Insurance Patients**
ARMC Physicians Care, Inc. accepts assignment for most major insurances. You will be required to pay applicable co-payments at the time of service and you are responsible for any coinsurance, deductibles, and payments for non-covered services.

**HMO/Managed Care Patients**
If ARMC Physicians Care, Inc. participates with your insurance you will be required to pay the applicable co-pay at the time of service. When required by your HMO/Managed Care plan, you are responsible for obtaining a referral from your Primary Care Physician. If you do not have a proper referral, you may be required to reschedule your appointment. If services are rendered without a valid referral authorization you will be responsible for payment.

**Liability Insurance**
If you are involved in an accident, we will be pleased to provide medical care for you. In most cases, we do not, however, file claims with third-party liability insurance plans.

**Methods of Payment**
We accept cash, check, VISA, MasterCard, and Discover. We do not accept post-dated checks, nor will we hold checks for any length of time.

**Returned Checks**
There will be a $25.00 returned check fee assessed for any and all checks returned from the bank for any reason.

**Minor patients**
For all services rendered to minor patients, the legal guardian accompanying the patient is responsible for payment.

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**Past Due Balances**
Patients with a past due balance at the time service will be asked to pay the prior balance in full before being seen. If the balance cannot be paid in full, then we may consider monthly payment arrangements.

**Information Changes**
Please advise us of any address, phone number, and insurance changes promptly.

**Form Completion Charge**
You will be charged a minimum of $25.00 for any forms you request the physician/nurse to complete (i.e. disability forms). This payment will be due at the time the completed forms are given to you.

**Refund Policy**
You may request a refund after all pended insurance claims have been processed. Any remaining credits on the account will be applied first to open balances and then can be refunded to the patient.

**Collection Procedures**
Members of our billing department are always available to help you with questions and concerns about your bill. Prompt payment for services rendered is expected and failure to comply or respond to repeated communications from our office may result in discharge from the practice and/or involvement of an outside collection agency. Once an account has been referred to an outside agency, prior balances must be resolved before being seen by a physician.

I have read and agree to the financial policies set forth by ARMC Physicians Care, Inc.

Patient Name: _____ Date:_____

Patient Signature: _____

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Patient Signature: _____

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**GENERAL CONSENT TO EXAMINATION**
**Alamance Regional Physicians Care**

ACCT#:

DOB:

AUTHORIZATION FOR TREATMENT–ASSIGNMENT OF BENEFITS–RELEASE OF MEDICAL INFORMATION

CONSENT TO EXAMINATION AND TREATMENT:

Knowing that I have a condition requiring medical treatment, I do hereby voluntarily consent to routine diagnostic and therapeutic procedures and medical care by Alamance Regional Physicians Care, my physician, and their assistants and designees. I further understand that the practice of medicine is not an exact science and that no guarantees have been made to me as the results of the care and medical treatment which I hereby authorized. I further understand that I may be required to relinquish private accommodations in the event they are needed for isolation purposes.

RELEASE OF INFORMATION:

I hereby authorize Alamance Regional Physicians Care to release to the Medicare Bureau, Health Care Financing Administration, or its Intermediaries or health insurers or carriers, any information about me needed for this claim, including medical information relating to my treatment. Only information needed for the purpose of processing any claim for payment of benefits may be released. I also authorize the release of medical and related information about my treatment to the Professional Review Organization responsible for reviewing the medical furnished by this institution. I also authorize the forwarding of copies of information from my medical records to accompany me on a transfer from this institution to another acute care hospital, intermediate care facility, skilled nursing home or nursing home as ordered by my physician. I authorize the release of copies of my medical record for this visit to my attending physician(s). I further authorize inspection of my medical record by the N.C. Department of Human Resources as specified in GS 130-9 (e) (1) and other relative legislation to insure this facility's compliance regarding licensure and certification. I have been further advised that I have the right to object in writing to such release and that my objection in writing may prohibit the inspection or release of my information. This authorization will expire two years from this date; however, I reserve the right to withdraw this authorization at any time.

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby assign and authorize payment directly to Alamance Regional Physicians Care of the benefits payable for Physician service benefits otherwise payable to me including payment of medical benefits, including Medicaid, but not to exceed regular charges for these services. I understand that I am financially responsible to the physician for charges not covered by this assignment.

_____ DATE:_____ _____ DATE:_____
WITNESS PATIENT/REPRESENTATIVE

GUARANTEE OF PAYMENT:

The patient agrees to pay and any undersigned guarantor hereby guarantees payment of all charges and expenses incurred for provider services. The guarantor is not relieved of his/her liability by an extension of time granted for the payment of these charges or expenses incurred, nor by the acceptance by the provider of a note of the patient or any third person. The guarantor waives homestead and all other exemptions. In the event legal action is necessary to collect the debt, patient guarantor, or any other parties responsible for payment of servers rendered shall be responsible for "reasonable attorney fees" at 15% of the outstanding balance pursuant to N.C.G.S. section 6-21.2 to the filing of any complain. In the event a Judgment is necessary to collect the debt, guarantor or any other parties responsible for payment of services rendered would be responsible for 18% interest from the date of the breach of payment to date of judgment.

_____ DATE:_____ _____ DATE:_____
WITNESS PATIENT

_____ DATE:_____ _____ DATE:_____
WITNESS GUARANTOR

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Burlington, NC 27215-8066

**NOTICE OF PRIVACY PRACTICES**
**Alamance Regional Physicians Care**

ACCT#:

DOB:

NOTICE OF PRIVACY PRACTICES AND PATIENT ACKNOWLEDGEMENT

To our patients: This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations creased as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

OUR COMMITMENT TO YOUR PRIVACY:

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information

**The following circumstances may require us to use or disclose your health information:**

1) To public health authorities and health oversight agencies that are authorized by law to collect information.
2) Lawsuits and similar proceedings in response to a court or administrative order.
3) If required to so by a law enforcement official.
4) When necessary to reduce or prevent a serious threat to your health and the safety or the health and safety of another individual of the public. We will only make disclosures to a person or organization able to help prevent the threat.
5) If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6) To federal officials for intelligence and national security activities authorized by law.
7) To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8) For Workers Compensation and similar programs.

**Your rights regarding your health information:**

You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. We will accommodate reasonable requests.

You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, bun not including psychotherapy notes. You must submit your request in writing to our practice address above. The contact phone number is (919) 568-7303.

You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our practice address above. The contact phone number is (919) 568-7303.

Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our practice at the address listed above. The contact phone number is (919) 568-7303.

Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact us at our practice address above. The contact phone number is (919) 568-7303.

Right to provide an authorization for other uses and disclosure. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

_____ DATE:_____ _____ DATE:_____
WITNESS PATIENT/REPRESENTATIVE