Carolina
HEART & LEG CENTER

3637 Cape Center Dr
Fayetteville, NC 28304
Phone: 910-491-1760

WELCOME TO OUR OFFICE

Name: _____ Today's Date: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Preferred method of Contact: _____

Home Phone: (____) _____ Work Phone: (____)_____ Cell Phone: (____)_____

Gender: _____ Race: _____ Email Address: _____

Preferred Language: _____ SSN:_____ DOB: _____

Employer: _____

Complete this section only if someone other than the patient is financially responsible:

Responsible Party:_____ Relationship:_____

In Case of Emergency, Contact: _____

Home Phone: (____) _____ Work Phone: (____)_____ Cell Phone: (____)_____

Referring Physician or Primary Care Physician: _____

INSURANCE INFORMATION

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company: _____

Where you hurt on the job: _____Yes _____No

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, co-pay and non-covered service amounts.

I authorize my insurance benefits to be paid to Carolina Heart and Leg Center, P.A.

I authorize Carolina Heart and Leg Center, P.A. to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

_____ _____

Signature of Patient Date

Carolina
HEART & LEG CENTER

3637 Cape Center Drive, Fayetteville, NC 28304
Medical History

MEDICAL HISTORY

Patient Name: _____ DOB: _____ Gender: _____

Drug Allergies: _____ Allergy to Iodine (X-Ray), Dye, or Shellfish: _____

Preferred Pharmacy: _____Pharmacy Phone Number: (___) _____

DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING: (Please describe as necessary)

_____Chest Pain
_____Angina
_____Heart Attack
_____Heart Catheterization
_____Angioplasty/Stent
_____Cardiac Bypass
_____Murmur
_____Heart Valve Problems

_____Rheumatic Fever
_____Heart Failure
_____Shortness of Breath
_____Leg Swelling
_____Heart Rhythm Problems
_____Palpitations
_____Dizziness
_____Fainting

_____Pacemaker
_____Defibrillator
_____Poor Circulation
_____Leg Pain or Cramps
_____Angioplasty/Stent to leg artery
_____Bypass Surgery to Legs
_____Carotid Artery Blockage or Surgery
_____Aortic Aneurysm or Surgery

_____High Blood Pressure
_____Diabetes Mellitus
_____High Cholesterol
_____Stroke or Mini Stroke
_____ Seizure
_____Brain Tumor /Aneurysm
_____Thyroid Problem or Surgery
_____Emphysema / Asthma
_____Lung Cancer
_____Blood Clots in Legs or Lungs

_____Liver Disease (Hepatitis or Cirrhosis)
_____Kidney Disease / Kidney Failure
_____Hemodialysis
_____Kidney Stones
_____Fibromyalgia
_____Lupus or Rheumatoid Disease
_____Bleeding Problems
_____Any Cancer :_____
_____
Previous Operations: _____
_____

_____Bleeding Ulcers
_____Gallstones or Surgery
_____Acid Reflux
_____Rectal Bleeding
_____HIV / AIDS
_____Anemia
_____Sleep Apnea

Personal Habits:
Tobacco Use: Cigarettes / Cigar _____/Day Chewing/Snuff Tobacco: _____Yes _____No

Alcohol Use: Type_____ Amount _____/Day

Family History:	Relationship	Age		Relationship	Age
_____Heart Disease	_____	_____	_____Diabetes	_____	_____
_____Sudden Death	_____	_____	_____High Cholesterol	_____	_____
_____ Hypertension	_____	_____	_____Stroke	_____	_____

Authorization: I hereby authorize Carolina Heart and Leg Center (physician/staff) to examine me and make such tests and perform such procedures as are reasonable and necessary for diagnosis of my condition and also consent to required treatment. I hereby authorize Carolina Heart and Leg Center, P.A. to release any medical information accumulated in my records during the course of my medical examination or treatment to any doctor, hospital or other health care agency if required so or felt deemed necessary in regard to my health/treatment. In addition, I hereby authorize the release of my medical information contained in any other doctor's office, hospital, or health care agency's records to Carolina Heart and Leg Center, P.A. to facilitate my medical care. I permit a copy of the above to be used in place of the original, which has been filed in the office of Carolina Heart and Leg Center, P.A

_____ _____ _____
Signature of Patient/Guardian Printed Name of Patient / Guardian Date

Carolina
HEART & LEG CENTER
3637 Cape Center Dr
Fayetteville, NC 28304
Phone: 910-491-1760

TB QUESTIONAIRE

Patient Name: _____

Date of Birth: _____

	Date:									
1	Have you had a persistent cough or 3 weeks or more?									
2	Have you been coughing up blood or 3 weeks or more?									
3	Have you had night sweats that soak your sheets?									
4	Have you unexplained weight loss?									

Carolina
HEART & LEG CENTER

3637 Cape Center Drive Fayetteville, NC 28304
Phone: 910-491-1760 Fax: 910-491-1764

Authorization to Release Information

Patient Name: _____ DOB: _____

_____ I hereby request a copy of my medical records as indicated below, be released to me.

_____ I elect to have these records mailed to me; records will be ready in twenty-one (21) business days.

_____ I elect to pick these records up in person; record will be ready in twenty-one (21) business days.

_____ I consent to and authorize: _____
Physician/Facility's Name Phone Number

_____
Address City State ZIP

to release my medical records to, as indicated below Carolina Heart and Leg Center, P.A.

_____ I consent to and authorize Carolina Heart and Leg Center, P.A., to release my medical records as indicated below, to:

_____
Physician/Facility's Name Phone Number

_____
Address City State ZIP

Please select the specific type of information to be released includes:

_____ History & Physical

_____Consults/Office Notes

_____Labs / X-rays / EKGs

_____Other (Specify) _____

_____Operative / Procedure Report(s)

_____ Emergency Department Notes

_____ Consults, Progress Notes (Hospital)

I Do _____ I Do Not _____ authorize the release of portions of the record relating to substance abuse, psychological / psychiatric conditions and/or communicable disease, including immunodeficiency virus (HIV), if present.

I understand that I may revoke this consent at any time in writing except to the extent that the information has already been released pursuant to this consent and before I have revoked my consent. Otherwise, this consent shall continue to be valid only for as long as reasonably necessary to carry out the purposes enumerated above or unless it is with release to an Insurance company for payment for medical and/or hospitalization benefits, it will automatically expire one year after date signed, whichever is the earliest date. I have been informed and understand that information disclosed pursuant to this authorization may be subject to re-disclosure by a recipient of such information It is possible that once disclosed the privacy of the information will no longer be protected under federal medical privacy law.

NOTE: Unless otherwise permitted by law, further release of this information is prohibited without prior written consent.

_____
Signature of Patient or Legal Representative Date

_____
State Relationship to Patient Phone Number

_____
Signature of Witness Date

Carolina
HEART & LEG CENTER

3637 Cape Center Drive
Fayetteville, NC 28304
Phone: 910-491-1760 Fax: 910-491-1764

Forms Completion Policy

Patient Name: _____ DOB: _____

Carolina Heart and Leg Center, P.A. requires payment for the completion of forms the patient asks us to complete on their behalf. We receive many requests which require increase administrative time and financial resources in excess of what is normally needed to complete the medical records.

Instructions:

- Submit the form completion request well in advance of when they are needed. We will attempt to complete the forms as quickly as possible however, to properly address them we need adequate time to review the patient's records.
- Patient must complete all their information on the form prior to giving the forms to us.
- Provide a stamped, addressed envelope to expedite mailing of completed forms.

We will make every effort to complete these forms within 7-10 business days; however, we cannot make any assurance of completion with the patient' time frame(s). Payment is required prior to completion of all forms.

The following forms will be assessed a $25 fee for completion:

- FMLA
- Workers Compensation
- Disability
- Letter of Condition
- Miscellaneous Patient request

Multiple page forms will be completed at no charge to the patient:

- DMV Disability Placard

By signing below, I attest that I have read and understand the above consent. I have been provided of copy of this document for my records.

_____

Signature of Patient or Legal Representative Date

_____

Printed Name of Patient or Patient Representative

Carolina
HEART & LEG CENTER

3637 Cape Center Drive
Fayetteville, NC 28304
Phone: 910-491-1760 Fax: 910-491-1764

Consent for Use/Disclosure of Health Information

Patient Name: _____ DOB: _____

Notice of Patient:

By signing this form, you grant us consent to use and disclosure protected health care information for the purposes of treatment, various activities associated with payment and healthcare operations. Our Notice of Privacy Practices provides more detail on our treatment, payment activities and healthcare operations. If there is not a copy of the Notice accompanying this consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your healthcare information.

As stated in our Notice a Privacy Practices, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Noticed. Since revisions may apply to your healthcare information, you have a right to receive a copy by contacting our Privacy Officer.

You have the right to revoke your Consent by giving written notice to our privacy officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this Consent we may decline to treat you.

You are entitled to a copy of this Consent form after you have signed it.

To be completed by Patient or Patient's Representatives

I, _____, have read the contents of this consent form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclosed my healthcare information to carry out treatment, payment activities and healthcare operations.

I, _____, give consent for Carolina Heart and Leg Center, P.A. to speak with _____, in regards to my payment options for patient responsibility. My relationship to this person is _____.

_____

Signature of Patient or Legal Representative Date

_____

Printed Name of Patient or Patient Representative Relationship

Our Privacy Officer can be contacted as follows:
Name of privacy officer: Trish Haynes
Practice address: 3637 Cape Center Drive, Fayetteville, NC 28304
Practice phone number: 910-491-1760 FAX: 910-491-1764

This form does not constitute legal advice and covers only had rolled not state laws.

Carolina
HEART & LEG CENTER

3637 Cape Center Drive
Fayetteville, NC 28304
Phone: 910-491-1760 Fax: 910-491-1764

Financial Policy and Assignment of Benefits

Patient Name: _____ DOB: _____

This document is to inform you of the financial policy established by Carolina Heart and Leg Center, P.A. We are committed to providing you with the best possible care and service; therefore, your complete understanding of our financial policy as it relates to your financial obligations is essential.

If your insurance plan requires you to have an **authorization** for a visit to a specialist office, please make sure your primary care physicians obtain such authorization for the initial visit and subsequent visits. **We are unable to provide service to you without a valid authorization.**

Your insurance plan is an agreement between you and the insurance carrier. You are ultimately responsible for all your medical expenses, and we will look to you for payment of any balances not covered by your insurance. It is the patient/guarantor's responsibility to follow and abide with the policy established by their insurance plans. If your plan requires that you select a specific provider of services, then it is your responsibility to do so and to notify your insurance company of such. If we are participating providers with your insurance plan, all insurance deductibles, copayments and coinsurances are due at the time of service. If we are not a participating provider with your insurance plan you are considered a self-pay patient, and responsible for all charges. We except cash, personal checks, money orders, MasterCard and VISA for payment of services rendered. Carolina Heart and Leg Center, P.A. will not file claims related to motor vehicle accidents or any other liability claims. As a service to our patient's we will bill your charges to your insurance company if you have provided us with the appropriate information. If you have a policy that pays to the patient only, the patient will be responsible for filing the claim. Should there be any unusual financial situations which would make payment difficult, please feel free to discuss this with your account representative. Payment plans are available.

Any patient payment will be first applied to the current co-pay/coinsurance and deductible, and after that the remainder of the payment will be applied to the oldest outstanding balance. Any past to balance (90 days) may be subject to additional collection fees. We reserve the right to refer any account to our collection agency if the account is in default of payment obligation or compliance of this policy. The collection agencies fee will be added to the outstanding balance.

MISSED APPOINTMENTS–If you are unable to keep an appointment please notify us 48 hours prior so that we may use that time for another patient. Medical emergencies or other unforeseen problems could delay your appointment. If this creates any inconvenience, rescheduling is available. If you cancel, reschedule or no show an appointment without giving us 48 hours there will be a $25 fee, for that missed appointment and for each missed appointment thereafter, or you may be discharged from the practice.

I hereby authorize Carolina Heart and Leg Center, P.A. to submit appropriate information to my insurance company for processing of my claim(s). I understand that the insurance benefits are paid directly to Carolina Heart and Leg Center, P.A. Furthermore, I agree to and understand that I am directly responsible for all financial obligations to Carolina Heart and Leg Center, P.A. If for any reason I fail to meet my financial obligations forcing Carolina Heart and Leg Center, P.A. to seek further actions as a means of collecting the balance owed (i.e. collection agency/court) I understand that I will be responsible for the balance due on my account plus all collection fees. If my account should be turned over to a collection agency, I understand that until such time that my financial obligations are met, I may no longer be seen as a patient at Carolina Heart and Leg Center, P.A. I further agreed to forever hold harmless Carolina Heart and Leg Center, P.A., their physicians and staff for refusal to render further services in the event I do not honor this financial agreement. I understand that for any services I do not pay in full, at the time the service is rendered; I assign benefits for that claim to Carolina Heart and Leg Center, P.A.

_____

Signature of Patient or Legal Representative Date

_____

Printed Name of Patient or Patient Representative