FamHealth
Primary Care P.A.
Caring Completely – Cuidado Completo

A NUESTROS PACIENTES CON SEGURO MEDICO:

Nuestro consultorio hace lo posible por confirmar los servicios aprobados por su seguro medico hoy. Nosotros nos encargaremos de enviar la cuenta a su seguro pero no existe garantia que su seguro pague por los servicios ofrecidos hoy. Al firmar esta forma usted afirma que es responsable por cualquier cantidad no aprobada por su seguro.

Firma del paciente o guardian: _____ Fecha:_____

TO OUR PATIENTS WITH HEALTH INSURANCE:

Our office has obtained and verified coverage for the medical services you'll receive today. We will file a claim for reimbursement with your health insurance. However, health insurance companies do not guarantee payment for services. By signing this form you take responsibility for payment of any amount not paid by your plan.

Patient (guardian) signature:_____ Date:_____

FamHealth Primary Care

Patient Registration Form

* **Patient:** Last Name _____ First Name _____ Middle Initial_____

* Street Address _____

* City_____ State _____ Zip Code_____

* Primary phone # _____ Secondary phone # _____ * Date of Birth _____

* Email _____ Marital Status: _____ Sex M or F (circle)

* Pharmacy (name and intersection/address/phone number) _____

* How did you hear about us? _____

* Reason for your visit _____

- - - - - - - - - - - -

If applicable: Person responsible if the patient is a minor (less than 18 yrs old): Relation to patient _____

Last name _____ First name _____ MI. ____ Primary phone # _____

Street Address _____City _____ State _____ Zip Code _____

- - - - - - - - - - - -

If applicable: Insurance Information

Policy number _____ Group/Plan# _____ ☐ Patient is subscriber – if so, you may skip the rest

Patient is: ☐ Spouse ☐ Child ☐ Other:_____ of Policy Holder. Policy Holder name _____ & DOB_____

Social Security # of policy holder (optional) _____ Employer Telephone (optional) _____

Company name (optional) _____

- - - - - - - - - - - -

Employer Information

Name of the Company you work for:_____ Telephone #:_____

Street Address:_____

City: _____ State: _____ Zip Code: _____ Fax #:_____

* I certify that the above information is correct. If the information above is incorrect and claims are denied, I understand that I will be immediately liable for the balance in full.
I hereby consent to your release or disclosure of information and medical records relating to your professional treatment of myself to other health care providers, hospitals, insurance companies, government agencies and others, including my employer, as you deem necessary for my professional care, for purposes of eligibility for coverage (including pre-admission certification) or payment under insurance and or Medicare benefit claims, for purposes of workmen's compensation claims, or such other purpose as may be required or permitted by law.

* Signature: _____ Today's date: _____

Relation to patient: _____ (only if patient is a minor)

FamHealth
Primary Care P.A.
Caring Completely — Cuidado Completo

Patient History / Historia del Paciente

Name / Nombre:_____ DOB / Fecha de Nacimiento_____

Symptoms—Please circle if in the last 2 weeks you have been experiencing any of the following symptoms

Sintomas – Por favor, marque con un círculo si en las últimas 2 semanas ha tenido alguno de los siguientes síntomas.

Fever / Fiebre	Unexplained weight loss / Perdida de peso inexplicable	Chills / Escalofrios	Changes in vision / Cambios en la vista
Difficulty swallowing / Dificultad a tragar	Problems with hearing / Problemas a oir	Cough / Tos	Wheezing / Resuello
Shortness of breath / Falta de aire	Stomach pain / Dolor en el estomago	Blood in stools / Sangrado en las heces	Constipation / Estreñimiento
Blood in the urine / Sangre en la orina	Nausea	Depression / Depresion	Anxiety / Ansiedad
Sore throat / Dolor de garganta	Swollen glands / Glandulas inflamadas	Joint pain or swelling / Dolor en las articulaciones o hinchazón	Weakness / Debilidad
Easy bleeding / Sangrando facil	Headaches / Dolores de cabeza	Loss of consciousness / Falta de conocimiento	Skin lesions / Lesiones en la piel
Ear aches / Dolor de oidos	Neck pain / Dolor de cuello	Back pain / Dolor de espalda	Chest pain / Dolor de pecho
Problems urinating Problemas para orinar	Vaginal discharge / Descarga vaginal	Dizziness / Mareos	Easy bruising / Moretones con facilidad

Medical History / Historial Medico Personal	**Year Diagnosed / Año diagnosticado**	**Family History / Historia Familiar**	**Famiy member / Miembro de la familia**
Heart disease / Problemas del corazon		Heart disease / Problemas del corazon	
High blood pressure / Pression alta		High blood pressure / Pression alta	
Diabetes		Diabetes	
Cancer		Cancer	
Do you smoke? / Usted fuma?		YES NO	
Do you drink alcohol? / Usted toma alcohol?		YES NO	
Do you use drugs? / Usted usa drogas?		YES NO	

FAMHEALTH PRIMARY CARE, PA

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **FamHealth Primary Care** 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 **FamHealth Primary Care** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **FamHealth Primary Care** 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 **FamHealth Primary Care, PA 5720 Creedmoor Rd Raleigh, NC 27612.**

With this consent, **FamHealth Primary Care** 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.
* **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."
***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 **FamHealth Primary Care** 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 **FamHealth Primary Care** 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, **FamHealth Primary Care** may decline to provide treatment to me.

Signature of patient or Legal Guardian

Print patient's Name or legal Guardian

Date:_____

FAMHEALTH PRIMARY CARE, PA
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of FamHealth Primary Care Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

The patient refused to sign.

Due to an emergency situation it was not possible to obtain an acknowledgement.

We weren't able to communicate with the patient.

Other *(Please provide specific details)*

_____

_____

_____

_____ _____

Employee signature *Date*

FAMHEALTH PRIMARY CARE, PA
5720 Creedmoor Rd Suite 100
Raleigh, NC 27612
919-782-0430 phone
919-782-0433 fax

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide medical health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communication

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways:

Treat you

- We can use your health information and share it with other professionals who are treating you.
- *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.
- *Example: We use health information about you to manage your treatment and services.*

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.
- *Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Note: In compliance with the NC mental health and substance abuse privacy laws we will not disclose mental health or substance abuse treatment information without your written consent.

Contact person: Miguel Pineiro, PA 919-782-0430

Effective: 9/1/16

FAMHEALTH PRIMARY CARE, PA
Patient Rights and Responsibilities

Our Practice is committed to providing quality health care. It is our pledge to provide this care with respect and dignity. In keeping with this pledge and commitment, we present the following Patient Rights and Responsibilities:

You have the right to:

- A personal clinician who will see you on an on-going, regular basis.
- Competent, considerate and respectful health care, regardless of race, creed, age, sex or sexual orientation.
- A second medical opinion from the clinician of your choice, at your expense.
- A complete, easily understandable explanation of your condition, treatment and chances for recovery.
- The personal review of your own medical records by appointment and in accordance with applicable State and Federal guidelines.
- Confidential management of communication and records pertaining to your medical care.
- Information about the medical consequences of exercising your right to refuse treatment.
- The information necessary to make an informed decision about any treatment or procedure, except as limited in an emergency situation.
- Be free from mental, physical and sexual abuse.
- Humane treatment in the least restrictive manner appropriate for treatment needs.
- An individualized treatment plan.
- Have your pain evaluated and managed.
- Refuse to participate as a subject in research.
- An explanation of your medical bill regardless of your insurance and the opportunity to personally examine your bill.
- The expectation that we will take reasonable steps to overcome cultural or other communication barriers that may exist between you and the staff.
- The opportunity to file a complaint should a dispute arise regarding care, treatment or service or to select a different clinician.

You are responsible for:

- Knowing your health care clinician's name and title.
- Giving your clinician correct and complete health history information, e.g. allergies, past and present illnesses, medications and hospitalizations.
- Providing staff with correct and complete name, address, telephone and emergency contact information each time you see your clinician so we can reach you in the event of a schedule change or to give medical instructions.
- Providing staff with current and complete insurance information, including any secondary insurance, each time you see your clinician.
- Signing a "Release of Information" form when asked so your clinician can get medical records from other clinicians involved in your care.
- Telling your clinician about all prescription medication(s), alternative, i.e. herbal or other, therapies, or over-the-counter medications you take. If possible, bring the bottles to your appointment.
- Telling your clinician about any changes in your condition or reactions to medications or treatment.
- Asking your clinician questions when you do not understand your illness, treatment plan or medication instructions.
- Following your clinician's advice. If you refuse treatment or refuse to follow instructions given by your health care clinician, you are responsible for any medical consequences.
- Keeping your appointments. If you must cancel your appointment, please call the health center at least 24 hours in advance.
- Paying copayments at the time of the visit or other bills upon receipt.
- Following the office's rules about patient conduct; for example, there is no smoking in our office.
- Respecting the rights and property of our staff and other persons in the office.