HEALTH ZONE MEDICAL PRIMARY & URGENT CARE

707 Lassiter Street
Smithfield, NC 27577
p-919-912-5160 f-919-938-0008

Today's Date:	Patient Chart #:

PATIENT INFORMATION

Patient's last name: First: Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ☐ M ☐ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Employer	Employer phone #:	Cell Phone #: ( )

Chose clinic because/referred to clinic by (Please check one box):	☐ Dr.	☐ Insurance plan	☐ Hospital

☐ Family	☐ Friend	☐ Close to home/work	☐ Yellow Pages	☐ Other

Email Address:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance	☐ [Insurance]	☐ [Insurance]	☐ [Insurance]	☐ [Insurance]	☐ [Insurance]

☐ [Insurance]	☐ [Insurance]	☐ [Insurance]	☐ Welfare *(Please provide coupon)*	☐ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

HEALTH ZONE PRIMARY & URGENT CARE FINANCIAL POLICY

Insurance is not payment in full and should not be treated as such. We will file your insurance as a courtesy for you, but we ask for your cooperation by providing us with the most current information.

In the event your insurance denies, suspends the claim for requesting information from you, or applies the amount to your deductible or co-insurance, the balance will be due immediately.

***Please refer to the policy below that pertains to you. If you are not able to adhere to these policies you will be asked to reschedule.

1) "Self-Pay" patients must pay the visit in full at the time of service. If payment in full is not possible, financial arrangements must be made with the staff prior to seeing the provider. A "down payment: of $60.00 for new patients and $60.00 for established patients will be required before being treated. The $60.00 for established patients is for a follow up visit only. If you are being treated for a follow up of acne, but also present with foot pain, there will be an additional cost. The full balance will be due immediately upon check out after services are rendered. Payments must be in the form of cash, or credit card. NO CHECKS!
2) Patients with co-payments listed on their insurance cards must pay that prior to being treated by the provider.
3) Medicaid adults 21 years of age and older must pay a $3.00 co-pay prior to being treated.
4) Patients with insurances with which we do not participate will be expected to pay in full at the time services are rendered. Refer to #1 listed above.
5) Patients who have been involved in an automobile accident will be able to file to their health insurance, but will not be allowed to file to a third party, such as Nationwide, GMAC, etc. If your insurance denies your claim due to your being involved in an automobile accident, then you are responsible for paying the bill and filing to your third party carrier. (See Office Manager if you have any questions).
6) Medical records requested by patients will be charged .25c per page. Medical records requested by other physicians will be free of charge. There is a $12.00 fee for FMLA paperwork, or any paperwork filled out by the provider.
7) There will be a $25.00 **RETURNED CHECK FEE.** All fictitious and fraudulent check writers will be prosecuted.
8) Carolina Access Medicaid patients require prior approval from their PCP (primary care provider) prior to being treated. It is your responsibility to obtain "authorization", but as a common courtesy we will attempt to contact your PCP prior to treatment. If we are unable to contact your PCP then a document must be signed by the patient/guardian of the patient stating they will be responsible if authorization is not given.
9) We do not accept Out-of-State Checks, Starter Checks or Checks from New Patients.

_____ _____

Date: Patient or Responsible Party Signature

ACKNOWLEDGEMENT OF RECEIPP OF HEALTH ZONE PRIMARY & URGENT CARE

HIPPA POLICY

We are required by law to maintain the privacy of, and provide individuals with, the notice of our legal duties and privacy practices with respect to Protected Health Information. If you have any objections to, or questions about this form, please ask to speak with our compliance officer.

Signature below is the only acknowledgement that you have read a copy of the Notice of Privacy Practices. You may have a copy I to keep upon request.

_____ _____

Date: Signature of Patient or Responsible Party

Health Zone Medical Primary & Urgent Care Office Policies for Patients

- We take our last patient 30 minutes prior to closing.
- We see patients 2 years of age and older.
- Please be aware that you may receive a bill or notice from Solstas Lab for labs performed at this office.
- We perform physical exams; however, we require that you bring the physical form to your visit (if you have a form that needs to be filled out) and if applicable any previous medical records.
- If you are a new patient and need a medication refill, you must bring your most recent medication bottle with you to your visit or be able to give a pharmacy name for verification of the prescription.
- We are unable to release medical information regarding the patient, unless patient is a minor, to anyone else other than authorized person stated below by the patient (see HIPPA law).

1. _____
2. _____
3. _____
4. _____

I have read and agree to the terms describe above:

_____ _____

Date: **Signature of Patient or Responsible Party**