Carolina East Medical Associates INC, would like to welcome you to our office. We work as a team with the goal of providing thorough medical care. We are always working to improve our care and service in any way possible. Please be advised of the policies below, if you have any questions, or concerns please feel free to let us know.

Financial Policy

We accept many types of insurances. As a courtesy we will file your insurance claim electronically following your visit. We cannot bill your insurance company unless you provide a current copy of your cards. Your insurance policy is a contract between you and your insurance company. ALL COPAYS ARE DUE PRIOR TO TREAMENT. Each chart is subject to a review following your visit. Your account will be billed for any appropriate charge adjustments made after this review.

If you don't have insurance and are "**Self Pay**", you will be responsible for up to $100 anything after $100 we will get you to sign a payment contract for and we will bill to the responsible parties address. Each chart is subject for a review following your visit. Your account will be billed for any appropriate charge adjustments made after this review.

Prescription Policy

If you want a refill of a prescription that you are already taking, you should call and request refills on the prescription line at ext 305. You cannot have a medication change for a current condition being treated for unless you are seen. Antibiotics are not a refillable prescription; you MUST be seen each time if you need this type of prescription. **PLEASE NOTE: THERE IS A 24-48 POLICY ON ALL PRESCIPTION REFILLS**. It could take up to this length of time for your pharmacy to receive the approved prescription. **THIS OFFICE DOES NOT WRITE PRESCIPTIONS OF NARCOTIC NATURE FOR A NEW PATIENT. REFILLS FOR A NARCOTIC PRESCIPTION FOR AN EXISTING PATIENT MUST BE SEEN EVERY 30 DAYS PER POLICY.WE WILL NOT TAKE OVER WRITING ANY NARCOTICS FROM ANOTHER PROVIDER**

Referral Policy

Please note all referral appointments may take up to 7-14 business days to be completed unless it is considered to be urgent. If you have any questions in reference to your referral appointment please leave a message for the referral coordinator at ext 304, and your call will be returned in the order that is was received. Please note if a referral is needed please ensure your contact information is correct in order for us to promptly inform you of your appointment time and place. Thank you in advance, for your cooperation in this matter it is greatly appreciated.

I hereby authorize that everything that I have read I agree and will comply with.

Patient Signature: _____

Carolina East Medical Associates
1201 Carolina Avenue
Washington, NC 27889

PATIENT DEMOGRAPHIC FORM

(THIS FORM IS TO BE UPDATED YEARLY OR WITH ANY INFORMATION CHANGES)

PATIENT INFORMATION

Patient Name: _____ Social Security # _____
Date of Birth_____ Sex: o Male o Female Marital Status: oS oM oD oW
Street Address: _____ Apt: _____
City: _____ State: _____ Zip Code: _____
Home Phone: ( ) _____ Work Phone: ( ) _____
Cell Phone: ( ) _____
Emergency Contact Name: _____
Emergency Contact Number: ( ) _____
*** If you would like to be reminded of your appointment via email please provide below****
Email Address: _____
Employer's Name: _____Work Phone: ( ) _____
Employer's Address: _____
City: _____ State: _____Zip Code: _____

PATIENT'S INSURANCE INFORMATION * Please provide ALL Insurance cards & Photo ID*

Primary Insurance Company's Name: _____
Insurance Address: _____
City: _____ State: _____ Zip Code: _____
Name of Policy Holder: _____ Date of Birth: _____
Insurance ID Number: _____ Group Number: _____

Secondary Insurance Company's Name: _____
Insurance Address: _____
City: _____ State: _____ Zip Code: _____
Name of Policy Holder: _____Date of Birth: _____
Insurance ID Number: _____ Group Number: _____

GUARANTOR/PARENT INFORMATION

Responsible Party Name: _____
(Last) (First) (Middle)
Relationship to Patient: _____ Date of Birth: _____
Social Security Number: _____-_____-_____
Address: _____ Apt: _____
City: _____ State: _____ Zip Code: _____
Home Phone: ( ) _____ Cell Phone: ( ) _____

GENERAL HEALTH HISTORY QUESTIONNAIRE (age 13 years or older)

Name: _____ _____ _____ Date: _____
(LAST) (FIRST) (MI)

Date of Birth _____ Male / Female _____ Race _____

SIGNIFICANT ILLNESSES

Do you or have you had: (please circle)

Diabetes	YES	NO
Cancer	YES	NO
Gout	YES	NO
High Blood Pressure	YES	NO
Heart Disease	YES	NO
Kidney Disease	YES	NO
Mental Illness	YES	NO
Abnormal Pap	YES	NO
Asthma	YES	NO
High Cholesterol	YES	NO

Other Illness not listed: _____

FAMILY MEDICAL HISTORY

Has any blood relative, including children, had any of the following:

			Relationship
Anemia	Y	N	_____
Bleeding Tendency	Y	N	_____
Cancer	Y	N	_____
Diabetes	Y	N	_____
Epilepsy	Y	N	_____
Heart Disease	Y	N	_____
High Cholesterol	Y	N	_____
Stroke	Y	N	_____
Tuberculosis	Y	N	_____
Colon Polyps	Y	N	_____

SOCIAL HISTORY

Tobacco History	Y	N	# years ____
Alcohol	Y	N	Drinks per week ____
Caffeine	Y	N	Cups/cans per week ___
Recreational Drugs	Y	N	Times per week _____
Exercise	Y	N	Times per week _____

HOSPITALIZATIONS/SURGERIES

List all reasons you were hospitalized	Year
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5.	

HEALTH SCREENING

Have you had			Date of Last
Physical	Y	N	_____
Pap	Y	N	_____
Chest X-ray	Y	N	_____
Tetanus Shot	Y	N	_____
MMR shot	Y	N	_____
TB test	Y	N	_____
Mammogram	Y	N	_____
EKG	Y	N	_____
Colonoscopy	Y	N	_____
Hepatitis Vaccine	Y	N	_____
Pneumonia Shot	Y	N	_____
Bone Density	Y	N	_____
Shingles Vaccine	Y	N	_____

ALL ALLERGIES (MEDICATIONS/FOODS/ETC)

	REACTION
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

MEDICATIONS

(List all medication you take on a regular basis including over the counter medications)

1. _____	6. _____
2. _____	7. _____
3. _____	8. _____
4. _____	9. _____
5. _____	10. _____

Your Pharmacy _____ Location _____
(example - CVS) (example - Bacon Rd)

Lab Consent

I authorize Carolina East Medical Associates, Inc to perform laboratory services in their facility located at 1201 Carolina Avenue, Washington, NC 27889, which will be sent to an independent testing facility for further testing/screening. Therefore, I understand I will be subject to receiving a separate bill from Quest Diagnostics.

Patient Signature: _____

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- •Treatment (including direct or indirect treatment by other healthcare providers
- involved in my treatment);
- •Obtaining payment from third party payers (e.g. my insurance company);
- •The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.
I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.
I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name _____ Date: _____

Signature _____ Relationship to Patient_____

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