Shelby Medical Associates, PA
711 N. DeKalb Street
Shelby, NC 28150
(704) 482-1482 • Fax (704) 482-0811

NEW PATIENT EXAM APPOINTMENT INFORMATION

Thank you for making an appointment with our office. Please take a moment to fill out the enclosed questionnaire. ***Bring the completed form to your appointment.*** DO NOT MAIL THE FORM AHEAD OF TIME.

Your instructions are as follows:

1. **Report to our office 30 minutes prior to your scheduled appointment time.** ***Failure to do so may result in your appointment being rescheduled.***

We encourage you to drink several glasses of water the day before and morning of your appointment so that you are well hydrated.

2. *If your appointment is in the morning*, do ***not*** eat or drink anything except water after midnight prior to your appointment.

3. *If your appointment is in the afternoon*, do ***not*** eat or drink anything except water for at least six (6) hours prior to your appointment.

4. Take all of your medications, except diabetic medications, on your normal schedule.

5. Bring all of the medications you are taking to the office with you. *Please list all medications as indicated on form, including all over the counter medications and vitamins.* It is very important that your provider review your current medications and dosages.

Shelby Medical Associates, PA
711 N. DeKalb Street
Shelby, NC 28150
(704) 482-1482 • Fax (704) 482-0811

Following these instructions will enable us to better meet your healthcare needs. If you have any questions, please call our office at (704) 482-1482.

Health Questionnaire

Date: _____

Name: _____ Date of Birth: _____

Email: _____

Things I want to discuss with doctor today: _____

MEDICAL HISTORY

Chronic Medical Conditions:

- o High Blood Pressure
- o Heart Disease
- o Diabetes
- o Stroke
- o Cancer
- o Thyroid
- o Asthma
- o Emphysema/Lung Disease
- o Kidney Problems
- o Anemia
- o High Cholesterol
- o Glaucoma
- o Arthritis

Other Medical Problems: _____

Please list any previous **Surgeries/Procedures** (and year)

Non-surgical Hospitalizations:

Please list all **Medications**, vitamins and herbal supplements you are now taking, dose (in milligrams), and how often:

Medication/Substance Allergy or Intolerance:

Immunizations & Screenings (include last date):

- o Tetanus _____
- o Influenza _____
- o Pneumonia _____
- o Hepatitis _____
- o Tuberculosis _____
- o Shingles _____
- o Breast/Mammo _____
- o Pelvic/Pap _____
- o Colonoscopy _____
- o Other _____

SOCIAL HISTORY

Marital Status _____

Do you use tobacco now? ___Yes ___No

Type & daily amount _____

How long? _____

Have you used tobacco before? ___Yes ___No

Street drugs _____

Occupation _____

Significant Stressors? ___Yes ___No

Exercise type _____ times/wk _____

Water _____ cups per day

Caffeine _____ cups per day

Alcohol _____ drinks per week

Do you have Living Will form? ___Yes ___No

Would you like a Living Will? ___Yes ___No

Do you feel at risk for AIDS or sexually transmitted disease? ___YES ___No

Lived or traveled outside of USA or Canada? _____

FAMILY HISTORY

	Living (Yes/No)	Age/Age-at-death	List medical disorders (diabetes, cancer, stroke, etc)
Father	___Yes ___No	_____	_____
Mother	___Yes ___No	_____	_____
Spouse	___Yes ___No	_____	_____
	(# = Number)		
Brothers	# Living_____	_____	_____
	# Dead _____	_____	_____
Sisters	# Living_____	_____	_____
	# Dead _____	_____	_____
Children	# Living_____	_____	_____
	# Dead _____	_____	_____

REVIEW of SYSTEMS (Circle if frequent or bothersome)		Physician Notes
General	Appetite Gain/loss, Weight Gain/Loss, Fatigue, Fevers, Chills, Sweats, Intolerance of Heat/Cold, Daytime-sleepiness, Severe-snoring	
Skin	Change in: Skin/Hair/Nails, Rashes/Hives, Itching Growths, Sores not healing, Warts/Moles/Lumps	
Eyes	Eye pain, Blurry-vision, Double-vision, Vision loss, Flashes of light, Glaucoma, Cataracts	
ENT	Hearing loss, Ringing in ears, Nose: Stuffy/Runny, Nose-bleeds, Sore: Tongue/Mouth, Bleeding gums	
Lungs	Cough, Sputum production, Cough up blood, Wheezing, Short-of-breath when Resting/Exertion Difficulty breathing, Excessive snoring Asthma, Tuberculosis, Asbestos-exposure	
Heart	Chest Pain/Tightness/Pressure, Swelling in Feet/Legs, Odd/Fast-heartbeats, Heart flutter, Fainting, Dizziness Leg cramps walking, Awaken short of breath	
GI	Trouble swallowing, Heartburn, Stomach pain Nausea, Vomiting, Constipation, Diarrhea Blood-in-stool, Black tarry stool, Daily laxative use	
GU	Genital problems, Burning with urination, Bloody / Dark urine, Frequent / Night urination, Trouble Passing / controlling urine, Night-urination, Change-in-cycle, Change-in-sexual-function	
MSK	Back-pain, Joints:Pain/Stiffness/Swollen, Arthritis Recent bone fracture, Muscle Aches/Weakness	
Neuro	Headaches, Dizziness, Difficulty speaking, Numbness Tingling, Burning-discomfort, Balance/Coordination, Falls, Loss of strength, Memory loss, Seizures	
Psych	Anxiety, Depression, Thoughts of suicide, Trouble sleeping, Hear voices when alone	

Any thing else your doctor needs to know about? _____

Shelby Medical Associates, PA
NOTICE OF PRIVACY PRACTICES

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.

If you have questions about this notice, please contact:
Regina Thomas, Privacy Officer

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information that may identify you and relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office at 704-482-1482 and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent

You will be asked by our office to sign a consent form. Once you have consented to use and disclosure of your protected health information for treatment, payment and health care operations by signing the consent form, your physician will use and disclose your protected health information described in **Section 1.** Your protected health information may be used and disclosed by your physician, our office staff and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and support the operation of the physician's practice. Following are examples of the types of uses and disclosures of your protected health information that the physician's office is permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office, once you have provided consent.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician, and call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you. We may get in touch with you directly or leave a message to remind you of appointments or for other reasons related to your care.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may use and disclose your protected health information for other marketing purposes. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Officer to request that these materials not be sent to you. At this time we do not engage in the use of protected health information for marketing purposes. We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer to request these fundraising materials not be sent to you. At this time Shelby Medical Associates, PA does not engage in associated fundraising practices.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: As you authorize, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practical after the delivery of your treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required by Law: We may use or disclose your protected health information to the extent that the law requires that use or disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We also may disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other governmental regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health agency authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose your protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may disclose your protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include: (1) legal processes required by law; (2) limited information requests for identification and location purposes; (3) pertaining to victims of a crime; (4) suspicion that a death has occurred as a result of criminal conduct; (5) should a crime occurs on the premises of the Practice; and (6) medical emergency (not on the Practice's premises) likely involving a crime.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may disclose protected health information to a funeral director, as authorized by law, in order for the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or to the public. We may disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel: (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility benefits; or (3) to foreign military authority if you are a member of that foreign military services. We may disclose your protected health information to authorized federal officials for conducting national security activities, including for the provision of protective services to the President or others legally authorized.

Worker's Compensation: Your protected health information may be disclosed by us as authorized to comply with Workers' Compensation laws and other similar legally established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. You may inspect and obtain a copy of your protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice use for making decisions about you.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and, protected health information that is subject to law that prohibits access to that information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. You may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to your requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by:

- Contacting our Privacy Officer to request a specific protected health information restriction;
- Completing any necessary and appropriate documentation of the requested restriction of protected health information; and
- Returning any/all necessary and appropriate documentation of the requested specific protected health information restriction to our Privacy Officer.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate ***reasonable*** requests. Reasonable is defined, for this purpose as being related to normal and customary business proceedings. We will alert a patient to an unreasonable request at the time of the request for alternate means of communication or alternate location. We may condition this accommodation by asking you information as to how your payment will be handled or specification of an alternate address or other method of contact.. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. You may request an amendment of protected health information about you in a designated record set for as long as we maintain the information. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. Complaints

You may file a complaint to Shelby Medical Associates, PA or to the Secretary of Health and Human Services if you believe your privacy has been violated. We will not retaliate against you for filing a complaint. Your complaint must be submitted in writing no later than 180 days from the perception of a violation related to your protected health information. To file a complaint at Shelby Medical Associates, PA, use the following address. You may contact our Privacy Officer at 704-482-1482 to discuss any perceived violation of your protected health information.

Attn: Privacy Officer
Shelby Medical Associates, PA
711 N. DeKalb Street
Shelby, NC 28150

To file a complaint to the Secretary of the Department of Health and Human Services, use the following address: Office of the Secretary, US Department of Health and Human Services, 200 Independence Avenue SW, Washington, DC 2020. To contact the Region IV Office of the Health and Human Services Office of Civil Rights, call: 404-562-7886.

Shelby Medical Associates, P.A.
711 N. DeKalb Street
Shelby, NC 28150
(704) 482-1482 • Fax (704) 482-0811

ACKNOWLEDGEMENT OF RECEIPT NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices for the above named medical practice.

_____
Patient Signature

FOR OFFICE USE ONLY

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

___ An emergency existed and a signature was not possible at the time.

___ The individual refused to sign.

___ A copy was mailed with a request for a signature by return mail.

___ Unable to communicate with the patient for the following reason: _____

_____

___ Other: _____

_____

Prepared By: _____

Signature: _____

Date: _____

Shelby Medical Associates, P.A.
711 N. DeKalb Street
Shelby, NC 28150
(704) 482-1482 • Fax (704) 482-0811

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Shelby Medical Associates, P.A. is authorized to release protected health information (PHI) about the below signed patient to the entity named below, in keeping with the instruction of the patient.

CHECK ALL THAT APPLY

☐ **VOICE MAIL. Release financial account information, lab test results and radiology test results to my Voice Mail attached to my phone numbers listed with the practice.**

☐ **SPOUSE. Release financial account information, and all medical health information related to my care to my Spouse:** _____
Name Phone

☐ **OTHER. Release financial account information, and all medical health information related to my care to the following person:** _____
Name Phone

THIS AUTHORIZATION SHALL BE IN EFFECT UNTIL REVOKED BY THE PATIENT.

I understand that I have the right to revoke this Authorization at any time and that I have the right to inspect or copy the protected health information as described in this document. I understand that such revocation is not effective if the information has already been disclosed, but will be effective going forward.

I understand that the information disclosed as a result of this Authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this Authorization and that my treatment will not be conditioned on signing.

_____
Signature of Patient or Personal Representative

SHELBY MEDICAL ASSOCIATES
PATIENT FINANCIAL POLICY

Thank you for choosing Shelby Medical Associates for your medical care. We value you as a patient and look forward to serving your healthcare needs. A good understanding of financial expectations is part of every physician-patient relationship. The following is our financial policy.

We accept the following forms of payment: cash, check, debit card, MasterCard, and Visa.

INSURANCE

• Our practice follows all insurance company required rules. If we participate with your plan and you are eligible for benefits, we will file your charges with your insurance company.
• ***Your insurance company requires we collect all patient payment responsibilities. Therefore, you will be expected to pay your co-payment, co-insurance and/or deductible amounts at the time services are rendered or your appointment may be rescheduled.*** Additionally, patients will be responsible for non-covered services the patient approves.
• In the event a lab, test or procedure is done, we will estimate your payment responsibility. You may be asked to pay your estimated payment at the time of your visit. Once your insurance has paid, you will be billed or refunded any difference between what you paid and the amount due after the insurance payment.
• If your insurance plan requires pre-certification or a referral or treatment authorization, it is ultimately your responsibility to ensure that the proper referral has been obtained. Any treatment without the necessary referral may result in a denial of payment by the insurance company, making payment for all charges your responsibility.

UN-INSURED

•If you do not have medical insurance, you will be responsible for payment of 50% of estimated charges at check-in plus any previous outstanding balance. If you cannot make this payment, your visit will be rescheduled, or you will be referred to the community health clinic. If a lab, test or procedure is necessary, 50% payment will be required prior to the procedure. We offer a 25% discount for payment in full at time of service.

MEDICARE

• We are a participating provider with Medicare. As an added service, if you have coverage secondary to Medicare, we file that for you. ***Your co-insurance and deductible amounts will be due at time of service or your appointment may be rescheduled.***

MEDICAID

• We are a participating provider with North Carolina Medicaid; however you must have your current card with you at time of service. Your card must have remaining visits to be valid. Please note that we do not accept managed care/HMO Medicaid, without proper authorization.

WORKERS COMPENSATION

• We will file your workers compensation claim as long as we have authorization for the services. If there is no authorization on file, payment is due when services are rendered.

OVERDUE ACCOUNTS

• We reserve the right to charge a fee for overdue accounts. ***If you need ongoing medical care, we expect payment on your old balance as well as payment in full for new charges at the time of service.***
Unresolved patient account balances will be turned over to a professional collection agency unless you are making timely payments on an approved payment plan.

NO SHOWS & CANCELLATIONS

•Please call ahead if you are unable to keep an appointment. 24 hours prior notice is required. We reserve the right to charge a fee for appointments that are missed or that are cancelled with less than 24 hours notice. If three (3) appointments are missed or cancelled without prior notice, you may be discharged from the practice.

***** PLEASE SIGN THE ACKNOWLEDGEMENT PAGE *****

ACKNOWLEDGEMENT OF RECEIPT OF PATIENT FINANCIAL POLICY

√ I have read the Patient Financial Policy and understand the policy.

√ I agree to pay at time of visit all co-pays, coinsurance and deductibles due for the visit, and to promptly pay all outstanding patient balance for services provided to me and/or my family.

√ All insurance payments for services rendered are assigned to this office. (A copy of this assignment is as valid as the original).

√ I understand that it is my responsibility to contact my insurance company should a claim be denied or not paid in full.

√ I understand that charges may occasionally be added or modified by my provider due to required corrections to services rendered or insurance claims billed.

√ I understand that I am financially responsible for all charges, whether or not they are covered by my insurance.

√ I authorize this clinic to release to my insurance carrier any medical information needed to obtain payment for services rendered.

√ I understand that if I disagree with any charges, I will contact this office in writing within 30 days of the billing date.

√ Should legal action be taken by this office to collect an unpaid balance due for medical services provided, I agree to pay reasonable attorney's fees or other such costs as the Court determines proper.

NOTICE: Do not sign this agreement before you read and agree to the conditions set forth in the Patient Financial Policy. You should keep a copy of this agreement in your records.

_____ _____

PATIENT SIGNATURE DATE

SHELBY MEDICAL ASSOCIATES, PA
PATIENT POLICIES

BECOMING A NEW PATIENT

All patients accepted by a physician as a new patient must complete and return all required forms prior to an appointment being scheduled. These forms include:

- Patient Data Sheet
- Health Questionnaire
- Acknowledgement of Receipt of Privacy Practices
- Authorization to Release Health Information
- Acknowledgement of Receipt of Patient Financial Policy
- Credit Card Authorization Form. All new patients must have a valid credit or HSA card and complete a credit card authorization form (debit cards are not an acceptable alternative). All credit card transactions at Shelby Medical Associates are secure.

All new patients must have an initial complete physical exam with a Shelby Medical Associates provider. This complete physical will be scheduled upon receipt of the above forms.

Shelby Medical Associates reserves the right to refuse acceptance of a new patient for operational, clinical, medical or financial reasons.

Please note that in the unfortunate event a patient must be discharged from the care of a Shelby Medical Associates provider, the patient is discharged from the entire practice and will be unable to receive medical care from any other Shelby Medical Associates provider.

MAKING AN APPOINTMENT

Patients are seen on a scheduled basis. To make an appointment, please call our office during regular office hours. Follow-up appointments also may be made with you during the check-out process following your completed appointment.

- Established patients will be scheduled as soon as possible based on the availability of appointment openings.
- Same-day appointment requests will be accepted on approval of the physician based on health condition, patient volume and patient status with the Practice.
- Walk-in patients will be seen only in cases of extreme emergency.

ARRIVAL FOR APPOINTMENTS

Established patients are requested to arrive at least 15 minutes prior to their scheduled appointment time; new patients are encouraged to arrive 30 minutes prior. This will allow time for check-in staff to review new patient forms and verify your personal or insurance information as needed, and collect any current or outstanding payments due.

Due to our commitment to providing each patient with the care and attention they deserve, in the event you do not arrive in time to complete the check-in process by your scheduled appointment time, your physician reserves the right to reschedule your appointment to another time and/or day.

Despite scheduled appointment times, your physician may be delayed in order to provide necessary care to a prior patient, or to address the needs of a hospitalized patient. We know that you would want the same attention to your medical care, and thank you for your understanding should your appointment be delayed. We understand that your time is valuable and will make every effort to keep you informed.

CANCELLATION OF AN APPOINTMENT

Please give at least a 24 hour notice if you will not be able to keep your appointment for any reason. This makes it possible for another patient to be seen in your place. Shelby Medical Associates reserves the right to charge patients $30.00 for missed or "no-show" appointments.

PATIENT FINANCIAL POLICY

Payment of all current and outstanding patient balances is expected at time of service, and we are required by your insurance plan to collect them. This includes co-pays, co-insurance, deductibles and previous outstanding balance. At minimum, co-pays and any outstanding balance will need to be paid prior to seeing your physician. Co-insurance and deductible amounts will be collected at time of check-

out to the extent they can be determined at that time. Once your insurance has been billed and a patient balance has been established, you will be advised of your balance and your credit card charged for the patient balance.

If you are unable to make required payments at time of service, your physician reserves the right to reschedule your appointment. If you are unable to make payments at time of service, you will be directed to a patient accounts representative so that payment arrangements can be made. Repeated failure to make required payments will result in discharge form the Practice.

For further information, please see our *Patient Financial Agreement.*

INSURANCE

Shelby Medical Associates participates with all major health insurance plans within our service area. It is recommended that you check with our office regarding participation with your specific plan. As a courtesy, we will bill your insurance company for charges incurred (patient payments required by your plan are due at time of service). Should your physician determine that a medical test, treatment and/or procedure is necessary, you will be responsible for full payment of fees in the event your insurance plan defines or determines that these will be "uncovered benefits".

Patients without insurance (private pay) will be required to pay $60.00 at time of service for an established patient office visit, and $200.00 at time of service for a new patient, consult or annual physical office visit.

BILLING

Following your visit, we will bill your insurance company for payment of their benefit amount. You are responsible for payment of all amounts and non-covered services that are not paid by your insurance company. Whether you are an insured or private-pay patient, your will receive an account statement at any time it is determined there is an amount owed by you. Your account statement will indicate the service provided and amount due. Your payment of any outstanding balance is due upon receipt of your account statement and your credit card will be charged in accordance with you Credit Card Authorization form.

Failure to pay your account in full within 90 days of notification of an outstanding balance will result in referral of your account to a professional collection agency and probable discharge from the Practice.

If you have any questions about your account or any statement received, we encourage you to contact our billing department at (704) 482-1482.

MEDICAL RECORDS

Shelby Medical Associates maintains strict confidentiality regarding your patient records. Therefore, unless specifically necessary for your medical care, medical information is only released with your written consent. For more information regarding the privacy and release of your protected health information (PHI) please see our *Notice of Privacy Practices.*

A completed *Medical Records Release Form* signed by the patient (or in the case of a minor or incompetent patient, signed by the parent, legal guardian or power-of-attorney) must be received before medical information is provided to anyone not directly involved in the provision of medical services specifically related to your care. Your Medical Release Form must be no older than six months from date of your signature.

When requested by a patient or a patient's legal representative, the cost of research and duplication of a patient's medical record is a minimum fee of $10.00 plus an additional amount for the number of pages copied. Authorization and pre-payment in full must be received five business days prior to the release of medical records copies.

FACILITY SAFETY

Shelby Medical Associates is a smoke-free facility. For the health and safety of our patients and staff we ask that you do not smoke in our offices or anywhere on our premises.

Shelby Medical Associates also is a no-firearm facility. For the safety of our patients, staff and visitors, no firearms are permitted in our offices.

SHELBY MEDICAL ASSOCIATES, P.A.
CREDIT CARD AUTHORIZATION FORM - RECURRING

At Shelby Medical Associates, our goal is to provide you with the best, most current medical care available in a positive and supportive environment. In order to do this, we must constantly strive to reduce and minimize our costs of doing business. Collection of patient payment responsibilities are critical to maintaining the quality of care you expect from Shelby Medical Associates.

In an effort make patient payments more cost effective for everybody, we are asking you to provide us with a credit card authorization. This approach is widely used by hotels, rental car agencies, gasoline stations, internet shopping sites, and mail order pharmacies.

Nothing will be charged to your credit card until the Explanation of Benefits (EOB) returns from your insurance company and we can accurately determine your patient payment balance. The only amounts charged to your credit card will be the PATIENT RESPONSIBILITY portion as defined by your insurance company's EOB, missed co-pays, returned checks, approved tests not covered by insurance, etc.

This information is confidential. This form will only be kept by Shelby Medical Associates Billing Department. Please complete and fax to (704) 480-6012.

Please enter all information.

PATIENT NAME: _____ ACCT #: _____

PHONE # (xxx-xxx-xxxx): _____ ALTERNATE #: _____

NAME AS ON CREDIT CARD: _____

CARD TYPE: ___ Visa ___ MasterCard EXPIRATION DATE (month /year): _____

CREDIT CARD #: _____ THREE DIGIT CV CODE: _____

I authorize Shelby Medical Associates, PA to charge my credit card with the balance due (patient responsibility) portion of my insurance explanation of benefits (EOB), and any charge not paid for by insurance. I understand that I can dispute the charge at any time with my credit card company; however the actual amount of the charge can only be disputed with my insurance company. If I feel the "patient responsibility" portion of the explanation of benefits (EOB) is inaccurate, I must resolve this issue directly with my insurance company. Any change in the EOB by the insurance company will be reflected as a credit or additional charge on my credit card.

AUTHORIZATION SIGNATURE: _____

DATE: _____