Ballantyne Medical Associates, PLLC.

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) 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:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

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

PHARMACY NAME: **ROAD:**

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	❑ UHC	❑ Cigna	❑ BCBS	❑ Wellpath	❑ Humana

❑ Aetna	❑ Medicare	❑ Medicaid	❑ 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 _____

EMAIL ADDRESS : _____ CELL PHONE NUMBER: _____

HIPAA

(Health Insurance Portability & Accountability Act)

Notice of Privacy Practices and Patient Rights

BALLANTYNE MEDICAL ASSOCIATES, PLLC

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) **to** carry out treatment, payment or health care operations **(TPO)** and for other purposes that are 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 that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses **and Disclosures of Protected Health Information**

Uses and **Disclosures of Protected Health Information**
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

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. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. 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.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. 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, as-needed, 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, and conducting or arranging for 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. We may also 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 to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: 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.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

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 use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. 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 'hat is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your unprotected health information. This means you may ask us not to use or disclose any part **of your protected health information for the** purposes of treatment, payment or health re-operations. You may also 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 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. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location, 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 alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information, If we deny your request for 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.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before **April 14. 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature _____ Date_____

BALLANTYNE MEDICAL ASSOCIATES, PLLC
PATIENT CONSENT FOR TREATMENT

CONSENT FOR TREATMENT: The below stated patient hereby authorizes the performance of any medical and/or surgical procedures under local or general anesthesia which may be advised and recommended by the clinic physician while a patient at BALLANTYNE MEDICAL ASSOCIATES, PLLC. The patient also consents to the performance of appropriate tests for the presence of infection such as, but not limited to, infection by Hepatitis B virus or the HIV virus if deemed necessary by the clinic physician for the protection of others including the withdrawal of blood or other body fluids for this purpose.

AUTHORIZATION **FOR RELEASE OF MEDICAL INFORMATION:** BALLANTYNE MEDICAL ASSOCIATES, PLLC is authorized to furnish medical information requested by insurance companies with whom I have coverage or any public agency which may be assisting in payment for my care or to any licensed physician who has accepted a referral from this office for my medical care.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign all my rights under any policy of insurance including, but not limited to, major medical insurance, hospital benefits, sick benefits or injury benefits due to me because of the liability of a third party such as auto insurance or worker's compensation insurance and the proceeds of all claims resulting from the liability of a third party payable by any person, employer, or insurance company to or for the patient up to the full amount of the clinic bill. In addition, I further warrant and represent that any insurance which I assign is valid insurance and in effect and that I have the right to make the assignment. Where Medicare and Medicaid benefits are applicable, I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act is correct and request that said payment of authorized benefits be made on my behalf.

PAYMENT GUARANTEE: The undersigned agrees to pay BALLANTYNE MEDICAL ASSOCIATES, PLLC any and all applicable charges incurred for services rendered to the below stated patient at the time of service.

PERSONAL PROPERTY: The clinic is not responsible for personal items of a patient i.e. jewelry, cash, appliances, etc.

The undersigned certifies that he/she has read the foregoing and is the patient or is duly authorized by the patient to execute the above and the acceptance of its terms.

X _____ _____

_____
Patient Date

X _____ Relation to Patient: **( )**
Spouse
Guardian or Responsible Party **( )** Parent
Other

X _____

Witness

X _____ I agree to allow Ballantyne Medical Associates to leave appointment information, lab results, test findings and/or pertinent medical information on an answering machine device or phone messaging device if necessary.

Ballantyne Medical ASSOCIATES

15640 Don Lochman Lane
Charlotte, NC, 28277
Phone: 704 540 1640 Fax: 704 540 1639
ballantynemedical.com

5/14/15

EFFECTIVE IMMEDIATELY---Patient Account Balances and Insurance Information

Dear Patients,

In a continuing effort to provide the best medical care, access, and convenience to all our patients, Ballantyne Medical Associates requests that our patients know and understand their insurance plan benefits especially in regards to deductibles, co-insurance, or co-payment amounts prior to any visit. These are due at the time of your visit; per insurance contracts. If your insurance plan does not cover a service or procedure, you are responsible for payment of these charges. To find out what your insurance plan covers and what your financial obligation may be, please call the customer service of your insurance company and become familiar with your specific policy.

We recognize that these have been financially trying times and want to always take care of you and your family. However, it is the policy of our clinic that prior to being seen, **50% of any outstanding balance on your account be paid**. If you are unable to do so, we will work to arrange payment plans with you for a period of **3 months**. If your account is placed into collections you will be responsible for fees incurred.

You are responsible to notify us of your insurance and any changes in coverage; failure to do so may cause you to be liable to pay the entire bill. Therefore, please have your current insurance card with you at all times, as well as a photo ID. As an informed patient and consumer, you are integral to helping us maintain your health.

Patient Name (Please Print):_____

Patient Signature (or representative): _____ Date:_____

Sincerely,

Ballantyne Medical Associates Administration

Ballantyne Medical ASSOCIATES

15640 Don Lochman Lane
Suite A Charlotte, NC, 28277
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ballantynemedical.com

EFFECTIVE IMMEDIATELY---Policy Regarding Paperwork/Forms/Records

5/22/2017

In a continuing effort to provide the best medical care, access, and convenience to all our patients, Ballantyne Medical Associates is implementing a new fee structure for forms that need to be filled out. We find this necessary due to multiple requests for forms from private parties (i.e. Attorneys), insurance companies, and others which take time away from direct patient care. There will be NO charge if the request comes from a government agency.

The following fee structure will be implemented for forms such as letters, disability criteria assessments, family medical leave documents, insurance documents, etc., which are not reimbursable by your insurance provider.

1. Medical Records Request from private entity (insurance companies, attorneys, etc.)--$50.00 processing fee
2. Forms (disability claims assessment, FMLA, etc.)
    a. 2 pages or less--$50.00
    b. 3-6 pages--$100.00
    c. 7-10 pages--$200.00
    d. More than 10 pages--$400.00

No Forms or medical record requests will be completed until the stated fees are paid.

We recognize that these have been financially trying times and want to always take care of you and your family. However, we are spending significant amounts of time on paperwork, which must always be done afterhours so as to not interfere with patient care. Thank you for your understanding. As an informed patient and consumer, you are integral to helping us maintain your health.

Patient Name (Please Print):_____

Patient Signature (or representative): _____ Date:_____

Sincerely,
Ballantyne Medical Associates Administration

Ballantyne Medical ASSOCIATES

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ballantynemedical.com

10/25/2012

To whom it may concern:

§ 90-411. Record copy fee.
A health care provider may charge a reasonable fee to cover the costs incurred in searching, handling, copying, and mailing medical records to the patient or the patient's designated representative. The maximum fee for each request shall be seventy-five cents (75¢) per page for the first 25 pages, fifty cents (50¢) per page for pages 26 through 100, and twenty-five cents (25¢) for each page in excess of 100 pages, provided that the health care provider may impose a minimum fee of up to ten dollars ($10.00), inclusive of copying costs. If requested by the patient or the patient's designated representative, nothing herein shall limit a reasonable professional fee charged by a physician for the review and preparation of a narrative summary of the patient's medical record. This section shall only apply with respect to liability claims for personal injury, and claims for social security disability, except that charges for medical records and reports related to claims under Article 1 of Chapter 97 of the General Statutes shall be governed by the fees established by the North Carolina Industrial Commission pursuant to G.S. 97-26.1. This section shall not apply to Department of Health and Human Services Disability Determination Services requests for copies of medical records made on behalf of an applicant for Social Security or Supplemental Security Income disability. (1993, c. 529, s. 4.3; 1993 (Reg. Sess., 1994), c. 679, s. 5.5; 1995 (Reg. Sess., 1996), c. 742, s. 36; 1997-443, ss. 11.3, 11A.118(b).)

I would like to point out the following about this statute as it pertains to your client, "XXXXX".

1. *"This section shall only apply with respect to liability claims for personal injury, and claims for social security disability…"* This statement is applicable to ***claims*** for disability. This patient does not have a balance with our office, therefore there is no claim. Since there is no claim involved with our office, it is not applicable.

2. *"This section shall not apply to Department of Health and Human Services Disability Determination Services requests for copies of medical records made on behalf of an applicant for Social Security or Supplemental Security Income disability."* We have not received a request for medical records from DHHS Disability Determination Services. If that department sends a request for medical records, we will send them a copy of the medical records.

We will forward a copy of your client's medical record to your office as soon as we receive a check for $50 since that is a better approximation of how much it will cost our office to retrieve and copy the file.

Sincerely,

Ballantyne Medical Associates Billing Dept.

_____

Patient Signature **Date**

Ballantyne Medical ASSOCIATES

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EFFECTIVE IMMEDIATELY: **7-13-12**

PLEASE READ- ALL PATIENTS:

Insurance Companies including Medicare have been dictating and are NOW ENFORCING how Physician offices across the country utilize data obtained during office visits to code and be reimbursed for visits.

Office visits will fall under **ONLY ONE OF TWO CATEGORIES:**

1. **PREVENTIVE/WELL VISITS** including Complete Physical Exams, Sport and School Physicals, and Biometric Exams.

2. **EPISODIC/PROBLEM ORIENTED VISITS** including **Management of Chronic Medical Conditions** such as asthma, diabetes, hypertension, high cholesterol, osteoarthritis, weight management **OR Sick Visits** including bronchitis, sinusitis, cellulitis, Acute Injury, New Onset of dizziness, abdominal pain, allergic reaction and urinary tract infection to name a few.

Visits that fall outside of these categories will be subject to **additional fees** which will most likely **NOT** be covered by your insurance. Since both the patient and medical office are bound by contract to comply with reimbursement policies we must make every attempt to collect these debts in addition to usual and regular co-pays and deductibles.

Please be understanding as we all get accustomed to these policies.

Patient/Guarantor Signature_____ Date _____

Respectfully,

Billing Department

8/13/12 as

Ballantyne Medical ASSOCIATES

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1/24/2013

EFFECTIVE IMMEDIATELY

Please be certain that each patient is fully aware of the individual details of their insurance plans. Specifically regarding Routine Physicals vs. Treatment of Acute or Chronic Medical Conditions and Testing associated with the same.

i.e.
Some plans cover problem related visits only while others cover routine visits only and specific testing associated with each.

The Doctor bases his decisions to treat and test on the medical necessity of each individual patient.

EFFECTIVE AS OF 10/31/2013

There will be a $50.00 charge for a regular office visit, failure to show or cancel your appointment 24 hours prior to your appointment time.

For procedures, i.e. Ultrasounds, Allergy Testing, Stress Tests, or CIMT there will be a $50.00 charge for failure to show or cancel your appointment 24 hours prior to your appointment time.

Signature: _____

Date: _____

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ALL PATIENTS PLEASE READ CAREFULLY

ALL your lab results will be posted to your secured and private electronic portal after reviewed by the physician. This is usually within 5-7 days after your blood draw. If the Physician feels your results require urgent attention we will contact you at the number you provided at your visit. **If you have trouble obtaining your results please contact our office.**

_____ _____

Patient Signature Date

Ballantyne Medical ASSOCIATES

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5/14/15

EFFECTIVE IMMEDIATELY – POLICY REGARDING PRESCRIPTION MEDICATIONS AND REFILLS

Dear Patients,

All prescriptions refills that are called in, sent via fax, or requested electronically have a turnaround time of at least 48-72 hours. While we respect and want to be as accommodating as possible, it is important for us to have the time to ensure that you will receive the correct medication/refills, and ensure that any necessary lab testing/monitoring is up to date. We often must verify with pharmacies and/or get authorization for the prescribed medications.

No controlled substances will be filled after hours or electronically. These must be called in during regular business hours and we will process them as quickly as possible. Please DO NOT call our after hour emergency line for these refills: we will not fill them. Again, any request for narcotic analgesics always require an office visit to be considered for refill.

Antibiotic therapy will not be prescribed without an office visit. We want to utilize the correct medication for patients when needed. Treating without a visit is not providing the optimal care we strive for. Please call for an appointment if you feel you need an antibiotic.

Thank you for your continued support and understanding.

Yours in health,

Ballantyne Medical Associates Administration

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Medication Refill Policy for Controlled Substances

Dear Patients:
In keeping with Federal and State Best Practices Guidelines and Standard of Care, patients requesting narcotics to treat an acute or chronic pain conditions will require a visit dedicated solely to this problem. Under no circumstance will any other refill of medicine for any other medical condition or issue be addressed at this time.

The above policy will also pertain to the evaluation of and continued use of amphetamine or amphetamine like substances used to treat narcolepsy or ADD/ADHD.
Thank you,

_____ _____
Print Name Date

_____
Patient Signature

Ballantyne Medical
ASSOCIATES

Late Arrival Policy

Our doctors, medical assistants and staff aim to make your visit a pleasurable one. In our efforts to make your visit more comfortable and to minimize your wait time, our office has implemented a late arrival policy.

If you are an established patient and you arrive more than 15 minutes late for an appointment, the appointment may need to be rescheduled. This is to ensure that the patients who arrive on time do not wait longer than necessary to see the provider. You may be given the option to wait for another appointment time on the same day if one is available. We will try to accommodate late-comers as best as possible, but cannot compromise on the quality and timely care provided to our other patients.

New patients are encouraged to print off new patient paperwork from the email previously sent or website and fill it out prior to coming in. Otherwise, new patients need to arrive at the office **at least 30 minutes** prior to the scheduled appointment to complete the paperwork. If a new patient's paperwork is not completed in a timely fashion upon arrival, we may need to accommodate other patients first who arrived on time and potentially need to reschedule the appointment.

The doctors and staff at Ballantyne Medical Associates truly appreciate your compliance and understanding with this policy so that we can continue to provide excellent medical care as well as excellent customer service. We apologize for any inconvenience this may cause, but it is in the best interest of all our patients.

_____

Patient Signature

_____

Date

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