New Hope Medical Clinic

Family Practice Walk-In

3670 South New Hope Road
Suite 1
Gastonia, Nc 28056

PATIENT INFORMATION

PATIENT NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE #: (_____)_____ - _____ WORK PHONE #: (_____)_____ - _____

E-MAIL: _____ SEX: FEMALE MALE

DATE OF BIRTH: _____/_____/_____ SOCIAL SECURITY NUMBER: _____

ETHNICITY/RACE_____ SPOKEN LANGUAGE_____

MARITAL STATUS: (circle one) SINGLE MARRIED DIVORCED WIDOWED OTHER

PATIENT RELATIONSHIP TO THE RESPONSIBLE PARTY: (circle one) SELF SPOUSE CHILD OTHER

PRIMARY CARE PHYSICIAN: _____ REFERRED BY: _____

PATIENT'S EMPLOYER INFORMATION: _____

CITY: _____ STATE: _____ PHONE #: _____

ACCIDENT INFORMATION: DATE OF ACCIDENT: _____ WORK RELATED? _____

AUTO? _____ OTHER: _____

RESPONSIBLE (OR INJURED) PARTY INFORMATION

RESP. PARTY NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____

HOME PHONE #: (_____)_____ - _____ WORK PHONE #: (_____)_____ - _____

DATE OF BIRTH: _____/_____/_____ SEX: FEMALE MALE

SOCIAL SECURITY NUMBER: _____

RESPONSIBLE PARTY'S EMPLOYER INFORMATION: _____

CITY: _____ STATE: _____ PHONE #: _____

PHARMACY INFORMATION

PHARMACY NAME: _____

ADDRESS: _____ PHONE #: _____

FAX # _____

INSURANCE INFORMATION (continued)

PRIMARY INSURANCE COMPANY: _____

ADDRESS: _____ PHONE #: _____

CONTRACT (ID#) NUMBER: _____ SUBSCRIBER'S NAME: _____

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle one) SELF SPOUSE CHILD OTHER

GROUP NAME: _____ GROUP NUMBER: _____

COPAYMENT AMOUNT: $ _____ INSURED'S DATE OF BIRTH: ____/____/____

WE APPRECIATE THE OPPORTUNITY OF SERVING YOU.
WE PLEDGE TO GIVE YOU OUR VERY BEST MEDICAL CARE.

OFFICE POLICY ON PAYMENT: It is our policy to require payment of all office charges at the time they are given, unless prior arrangements have been specifically made. All accounts over 60 days will be charged an interest rate of 1.1/2 percent per month (18% per annum) or a $2.00 minimum. In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agree to pay all costs charged by the collection company, which costs will not exceed 20% of said unpaid balance, including a reasonable attorneys fee.

INSURANCE POLICY: Insurance provides for your reimbursement on allowed medical charges. As a courtesy to you we will provide an itemized statement you may send to your insurance company for payment. We will be happy to submit to most insurance carriers, if you have provided us with policy numbers, address, place of employment and any other pertinent information. You are responsible for all deductibles and charges not covered by insurance. Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility.

I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS: I authorize the Doctor to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when the Doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of the information.

I have read the above and accept financial responsibility in full for this account.

SIGNED: _____ **DATE:** _____
Patient, Parent, or Guardian

IN CASE OF EMERGENCY PLEASE CONTACT:

NAME: _____

PHONE NUMBER: _____ RELATIONSHIP: _____

ADDRESS: _____

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Family Practice
Walk-in

Notice of Privacy Practices

To our patients, This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIP AA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you. including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to New Hope Medical Clinic, 3670 S. New Hope Rd., Suite 1, Gastonia, NC 28056 (704) 824-4560.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to New Hope Medical Clinic, 3670 S. New Hope Rd., Suite 1, Gastonia, NC 28056 (704) 824-4560. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health And Human Services. To file a complaint with our practice, contact New Hope Medical Clinic, 3670 S. New Hope Rd., Suite 1, Gastonia, NC 28056 (704) 824-4560. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact New Hope Medical Clinic, 3670 S. New Hope Rd., Suite 1, Gastonia, NC 28056 (704) 824-4560.

I hereby acknowledge that I have been presented with a copy of New Hope Medical Clinic's Notice of Privacy Practices.

Signature _____ Date _____

Name of Patient _____

Personal Representative Authorization

☐ I **do not** wish to select a personal representative.

☐ I authorize the following individual(s) to serve as my/patient;s Personal Representative with full authority to access or authorize review, release and/or copying of my/patient's medical records (*Please write relationship beside name.*)

1)_____ 2) _____

3)_____ 4) _____

I may revoke this request in writing, at any time except to the extent that action based on this authorization has already taken place.

Signature _____ Date _____