Raleigh Associated Medical Specialist
3414 Six Forks Rd
Raleigh, NC 27609

PATIENT REGISTRATION FORM

Name:_____ Marital Status: S/M/W/D/SEP Date of Birth:_____

Street Address: _____ City/_____ State/Zip:_____

Phone: Home: _____ Work: _____ Cell:_____

Race: C-Caucasian____ B-Black ____ State DL/ID # _____ SS#_____

Other_____ Ethnicity: H- Hispanic____ N-Non-Hispanic_____ D-Decline_____

Primary Language:_____

Emergency Contact:_____ PH:_____ Relationship:_____

Referred By:_____

Policy1/Insurance Company:_____ Policy ID# _____ Group#_____
Name of Policy Holder:_____ Date of Birth:_____ Relationship:_____

Policy2/ Insurance Company:_____ Policy ID# _____ Group#_____
Name of Policy Holder:_____ Date of Birth:_____ Relationship:_____

Assignment of Insurance Benefits

I hereby authorize direct payment of surgical/medical benefits to Raleigh Associated Medical Specialist for services rendered. I understand that I am financially responsible for any balance not covered by my insurance.

Authorization to Release Information

I hereby authorize Raleigh Associated Medical Specialist to release any medical information that may be necessary for either medical care or om processing applications for financial benefits.

Signature:_____ Date:_____

CHRONIC LABS
1._____
2._____
3._____
4._____

RAMS HEALTH MAINTENANCE SUMMARY

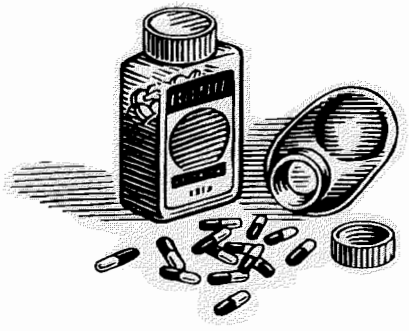
Name: _____ DOB: _____
Patient's Phone Number (____) _____-_____
PHARMACY: _____ PHARMACY PHONE: _____

CHRONIC PROBLEM LIST		MEDICINE ALLERGIES:	FOOD ALLERGIES:
		SURGICAL HISTORY:	DATE:
		PATIENT'S SPECIALIST:	SPECIALITY:
SOCIAL HISTORY:		FAMILY HISTORY: (WHICH MEMBER)	
OCCUPATION:		HEART DZ	BREAST CA
SPOUSE:M/S/D/SEP		HYPERTENSION	COLON CA
Children:# ages:		STROKE	LUNG CA
Caregiver Name:		DIABETES OTHER_____	PROSTATE CA OTHER_____

YEARLY SCREENINGS

DATE	2012	2013	2014	2015	2016	2017	2018	2019
RACE: AGE:								
FEMALE:								
MAMOGRAM								
PAP SMEAR								
MALE:								
PSA: (PROSTATE EXAM)								
50+ SCREENINGS								
COLONSCOPY								
DEXA (BONE DENSITY)								
ADVANCE DIRECTIVE								
LABS DATES								
CHOL(TOTAL)								
HDL								
LDL								
CREAT								
TSH								
INR								
LIFESTYLE:								
SMOKES/DAY/ X YRS				DATE QUIT				
ALCOHOL INTAKE				DATE QUIT				

RALEIGH ASSOCIATED MEDICAL SPECIALIST



MEDICATION LIST

Patient's Name_____ **DOB:**_____

Medication	Dosage	How many times per day

RALEIGH ASSOCIATED MEDICAL SPECIALISTS
3414 SIX FORK RD
PO BOX 28145
RALEIGH, NORTH CAROLINA 27609
PHONE: 919 783-0200 FAX: 919 783-0203

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use or disclose of the named individual's health information as described below:

Patient Name	Date of birth	Social Security Number
Telephone:	Address(Street, City, State, Zip)	

My Information may be disclosed and released to the following individual or organization

- ☐ Raleigh Associated Medical Specialists, Inc.
- ☐ Other(please specify)_____
  Please insert name of individual that information is to be released to.
- ☐ Other(please specify)_____
  Please insert name of individual that information is to be released to.

The following information is be to disclosed: (Please check one box for each item)

YES	NO	
☐	☐	.....Physician Notes
☐	☐	.....Lab Results
☐	☐	.....X-Ray Reports(this includes X-Ray, MRI's, Ultrasounds)
☐	☐	.....Cardiac Record
☐	☐	.....Complete Record
☐	☐	.....Other_____

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or infection with Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental services or treatment for alcohol and drug abuse.

Re-disclosure: I understand that any disclosure of information carries with it the potential for re-disclosure and the information then my not be protected by federal confidentiality rules.

Right to revoke: I understand that I have the right to revoke this authorization at anytime. I understand that my revocation must be in writing. I understand that the revocation will not apply to information already released based on this authorization.

Other rights:

a) I understand that authorizing the disclosure of this health information is voluntary. I refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.
b) I understand that I may inspect or obtain a copy of the information to be used or disclosed.

Expiration: Unless otherwise revoked in writing, this authorization will become permanent.

Signature of patient or legal representative: Date:

If signed by legal representative, relationship to patient:

Raleigh Associated Medical Specialist

Financial Policy

Raleigh Associated Medical Specialists is built on providing the best in medical care to our patients. Such care is provided on a relationship of mutual understanding and respect.

Insurance

We participate with various insurance plans and will directly bill your insurance carrier under these plans. In order to honor your insurance benefit agreements, please present a current insurance card at each visit. We will accept assignment of benefits for those companies that we are contracted with as in-network providers. We will file primary for all plans with whom we are currently contracted.

Your medical coverage plan is a contract between you and your insurance carrier. We can not and will not accept responsibility for negotiating claims with insurance companies. You are responsible for all co-payments, co-insurance, deductibles, and procedures not covered by your insurance carrier at the time of your visit. All outstanding balances, regardless of insurance status are to be paid within forty-five (45) days of receiving notice of the amount is due. Request for duplicate forms or processing additional information such as life insurance, school forms, and disability forms may be charged for professional time involved. We cannot guarantee payment of your benefits only your insurance carrier can. Acceptable forms of payments: Cash, Check,Visa, Mastercard, American Express, Discover, and Health Spending Plans.

Out of Network and Self Pay

We strive to provide affordable healthcare by working with a variety of insurance carriers. However, for those who are "self paying" individuals we will offer a discount if all charges are paid in full at the time of service. If we do not contract with your insurance, you will be expected to pay the charges in full and we will supply you with the insurance claim form to file with your insurance carrier.

Medicare

We are a participating provider with Medicare. We accept the fees set by Medicare for medical services covered by the Medicare program. Medicare patients will be responsible for co-insurance, annual deductible amount and non-covered services, which are not covered by your primary or secondary policies. We do not participate with (Medicare HMO Plans), (Medicare Complete), or (Humana HMO).

Missed appointments/Cancellations

Our Policy is to charge for missed appointments or appointments canceled with less than 24 hours notice at rate of $25. This fee is not covered by your insurance plan and is your responsibility. Our policy, at the discretion of the providers is to terminate a patient from the practice after 3 missed/canceled (without 24 hours notice) appointments.

Insufficient Funds

It is our policy to charge a fee of $25 for all returned checks due to insufficient funds, or any stopped payment on an issued check.

Refunds

It is not our policy to issue refunds if your account has an insurance claim pending. When all claims have been paid, any remaining credit may be refunded. Refund checks are generally issued annually.

Medical Records

All documents and material contained in the patient's medical records are confidential. Besides doctor's notes and test results this includes paper, digital and electronic correspondence, as well as any images that are used to document patient care. RAMS will retain the ownership rights to digital or electronic correspondence or other images, and the patient will be granted access to view them or obtain copies. These images will be stored on a secure manner that will protect patient privacy and they will be kept for the time period required by law or outlined in RAMS policy.

All documents and material in the medical record will be released and/or used outside RAMS only upon written request from the patient or legal representative. Request for copies of medical records will be completed within a reasonable period of time as photocopying of medical records.

The providers at RAMS may consult with outside colleagues regarding treatments should such consultation be deemed necessary in order to provide the highest quality of treatment. Patients should notify their physician of any contact they do not authorize.

I,_____, have read, understand, and agree to comply fully with the above policies. I recognize and accept full financial responsibility for all professional services rendered.

_____ _____

Signature of Patient/Responsible Party Date

Please provide Raleigh Associated Medical Specialist with an E-MAIL account in order for us to send you your medical information.

_____@_____._____

Name:_____ DOB:____/____/_____

Address_____
_____

Telephone #_____