Primary & Immediate Care
of the Pines

Bertha Taylor-Miller, FNP-BC

Phone: 910-716-0099 Fax: 910-405-1359

211 Bonnie Brook Rd., Aberdeen, NC 28315

First Name: _____ Middle Name: _____ Last Name: _____

Social Security Number: _____ Date of Birth: _____

Gender: ___ Male ___Female

Mailing Address: _____

City: _____State: _____ Zip: _____

Primary Phone: _____ *(Circle One)* Home / Cell / Work

Email:

_____

Have you traveled outside the USA in the last 6 months? ____Yes ____ No

Race: *(Circle One)* American Indian/Alaska Native Asian Black/African American Native Hawaiian Pacific Islander White More than one race Do not wish to report

Ethnicity: *(Circle One)* Hispanic/Latino Non-Hispanic/Latino Do not wish to report

Marital Status: (*Circle One)* Married Single Divorced Widowed

Preferred Language: English Spanish Other: _____

Emergency Contact: *(Name, Relationship, & Phone)*

_____

Primary Care Physician: (*Name and Phone)*

_____

Primary Insurance Name: _____

Secondary Insurance Name: _____

Preferred Pharmacy: *(Name, Address, & Phone)* _____

Employer: (*Name/phone)*_____

Primary & Immediate Care
of the Pines

Consent for Treatment

I hereby authorize the release of medical information related to the services rendered. I attest the insurance information is correct and I authorize payment of medical benefits directly to the physician.

Signature: _____

I have been informed of the availability of chronic care management services. I consent to electronic communication of medical information with information/ with other treating practitioners and providers.

Signature: _____

Financial Consent

I understand that payment for services provided by Primary and Immediate Care of the Pines will be my responsibility. My insurance carrier will be billed for these services as a courtesy and my uncovered charges, deductibles, or co-pays will be my responsibility. I hereby assign all medical benefits, if any, payable directly to this medical practice. I authorize the release of all information necessary to secure payment of benefits. I authorize Primary and Immediate Care of the Pines to submit claims to my insurance carrier in order to obtain payment for professional services rendered.

By signing below, I understand and agree that in the event of default, I am legally liable for all costs of collections including collection fees, court costs, and all other costs related to the collection of this debt.

Signature: _____ Date: _____

Primary & Immediate Care
of the Pines

Medication Refill Policy

- It is your responsibility to notify the office in a timely manner when refills are necessary. Approval of your refill may take up to two (2) business days. Please be courteous.

- If you use a mail order pharmacy, please contact us (7) seven business days before your medication is due to run out.

- Medication refills will only be addressed during regular office hours. (Monday-Thursday 8am – 5pm)

- NO prescriptions will be refilled on Saturday, Sunday or the Holidays.

- Refills can only be authorized on medication prescribed by our providers from our office.

- We will NOT refill medications prescribed by other providers.

- Some medications require prior Authorization. Depending on your insurance, this process may involve several steps by both your pharmacy and the provider. The providers and pharmacies are familiar with this process and will handle the prior authorization as quickly as possible. Neither the pharmacy nor the provider can guarantee that your insurance company will approve the medication. Please check with your pharmacy and insurance company for updates.

- It is important that you keep your scheduled appointment to ensure that receive timely refills. Repeated no-shows or cancellations will result in a denial of refills.

- If you have any questions about your medications, please address them during you office visit. If for any reason you feel your medication needs to be adjusted or changed please contact our office immediately.

- New symptoms or events require an examination by the provider. We will NOT diagnose or treat over the phone.

Patient Signature: _____ Date: __/___/____

Primary & Immediate Care
of the Pines

Controlled Substance Medication Agreement

I understand and voluntarily agree that:

- I will keep (and be on time for) all my scheduled appointments with the provider.
- I will keep the medicine safe, secure, and out of the reach of children. If the medicine is lost or stolen, I understand it will not be replaced until my next appointment and may not be replaced at all.
- I will take my medication as instructed and not change the way I take it without first talking to the provider.
- I will not call between appointments for refills.
- I will always treat the staff of the office respectfully. I understand that if I am disrespectful to the staff or disrupt the care of other patients, my treatment will be stopped.
- I will sign a release form to let the provider speak to all other providers that I see. I will inform the provider all other medications that I take and let them know right away if I have a prescription for a new medication.
- I will not get any opioid pain medicines or other medicines that can be addictive such as benzodiazepines (Klonopin, Xanax, valium) or other stimulants (Ritalin, amphetamine) without telling the provider before I fill that prescription.
- I will not use illegal drugs such as heroin, cocaine, marijuana, or amphetamine without telling the provider before I fill that prescription.
- I will come in for drug testing and counting of my pills on the day I am notified. I understand that I must make sure the office has current contact information to reach me and that any missed tests will be considered positive for drugs.
- I understand that I may lose my right to treatment in this office if I break any part of this agreement.
- I will use only one pharmacy to get all my medications
- I understand that PIC does not do chronic pain management and therefore will not fill/refill chronic pain medications, nor bridge medications while awaiting Pain Management appointment.
- We will follow the STOP ACT requirements regarding ACUTE pain.

Printed name: _____

Signature: _____

Date: _____

Primary & Immediate Care
of the Pines

*******NO SHOW/CANCELLATION POLICY*******

We understand that sometimes you need to cancel or reschedule your appointment and that emergencies do happen. If you are unable to keep your appointment, please call us as soon as possible (at least 24 hours' notice), to allow other patients to be seen in a timely manner. You may do so by calling 910-716-0099.

As a courtesy, a reminder call is made one day prior to your scheduled appointment. However, it is the responsibility of the patient to arrive at their scheduled appointment time or notify the office.

Effective immediately, after the first missed appointment, the patient will receive a "NO SHOW" phone call or letter of warning. After the second missed appointment, a "NO SHOW" fee of $25 will be billed to the patient. This fee is not covered by insurance. After the third missed appointment, dismissal from the practice will be considered.

Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____

Printed Name Date

_____

Signature

Primary & Immediate Care
of the Pines

PERMISSION TO PHOTOGRAPH

I agree that Primary & Immediate Care of the Pines (PIC) may take a digital photo of me. I understand that:

- The photo will be stored permanently in my medical record.
- The photo will be used to identify me when I come here for care.
- The photo will be stored securely to protect my privacy.
- The photo will **NOT** be used outside of PIC, unless I (or my legal representative) give permission in writing.
- PIC will own the photo. I can look at the photo.

_____
Patient Signature (or authorized representative)

_____
Relationship to Patient

_____
Date

I decline to have my photo taken:

_____
Signature

_____
Date

Primary & Immediate Care
of the Pines

Bertha Taylor-Miller, FNP-BC

Phone: 910-716-0099 Fax: 910-405-1359

211 Bonnie Brook Rd., Aberdeen, NC 28315

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____
DOB: _____
Today's Date: _____

I hereby authorize the disclosure of my health information as described below:
(Please check purpose of release):
____ Transfer of Care
____ Copy or Record
____ Ongoing Communication

I hereby consent to and authorize the release of requested Health Information: **(if more than 20 pages please mail**)

RELEASE TO: Primary & Immediate Care of the Pines
211 Bonnie Brook Rd., Aberdeen, NC 28315
Phone: 910-716-0099 Fax: 910-405-1359

RELEASE FROM: _____

Phone: _____

Fax: _____

Check all specific information that is to be released:
____ All Records ____ Emergency Care
____ Lab/Pathology Reports ____ Operative Reports
____ Other _____

I DO ___ DO NOT ___ authorize the release of portions of the record relating to substance abuse, psychological/psychiatric conditions, and/or communicable disease, including AIDS if present. I understand that this consent is revocable except to the extent that action has already been taken. This consent will automatically expire 1 year from the signature date, unless another date is specified below.

_____
Signature of Patient or Parent/Legal Guardian

Primary & Immediate Care of the Pines

PERSONAL MEDICAL HISTORY

Please check all that apply:

____ ADHD
____ Alcohol Abuse
____ Anxiety
____ Arthritis
____ Asthma
____ Cancer/Type _____
____ Constipation/Diarrhea
____ COPD
____ Depression
____ Diabetes/Type: _____
____ High Cholesterol
____ Glaucoma
____ Heart attack
____ Heart Disease
____ Heartburn/reflux
____ High Blood Pressure
____ Kidney Disease
____ Migraines
____ Obesity
____ Stroke
____Substance Abuse
____ Thyroid Disorder

OTHER: _____

Please list any hospitalizations or surgeries:

HOSPITALIZATIONS/SURGERIES	DATE

FAMILY HISTORY

Please check all that apply:

	PATERNAL GRANDPARENTS	MATERNAL GRANDPARENTS	FATHER	MOTHER	SIBLINGS	CHILDREN
Alcoholism						
Allergies						
Anxiety						
Breast Cancer						
Colon Cancer						
Lung Cancer						
Prostate Cancer						
Skin Cancer						
COPD						
Depression						
Diabetes						
Heart Disease						
Hypertension						
Stroke						

Primary & Immediate Care
of the Pines

SOCIAL HISTORY

Tobacco Use: ____ Every day ____ Some Days ____Former ____ Never
Packs per day: _____ Per week _____

Alcohol Use: ____ Yes ____ No
Drinks per day: _____ Per week ____
What type of alcohol: _____

Illicit Drug use: ____ Yes ____ No
What used: _____

Occupation: ____ Student ____ Unemployed ____ Employed ____ Retired ____ Disabled

Do you wear a seatbelt at all times? ____ Yes ____ No

PREVENTATIVE CARE

List if you have had the following and the date:

Tetanus vaccine _____
Pneumonia vaccine _____
Flu Vaccine _____
Hepatitis B vaccine _____
Shingles vaccine _____
Mammogram _____
Pap smear _____
Colonoscopy _____
Prostate Cancer test _____
Eye exam _____

Primary & Immediate Care
of the Pines

MEDICATION LIST/ALLERGIES

In an effort to provide the best quality patient care, PIC needs a complete list of all of your medications. This should include prescribed medications, over-the-counter medications and herbal medications/supplements.

Please bring **ALL** medications to each visit.

MEDICATION	DOSAGE	FREQUENCY

ALLERGIES:

MEDICATION NAME	REACTION

Primary & Immediate Care of the Pines

HIPAA (Health Insurance Portability & Accountability Act of 1995) is a federal regulation requiring that we provide you with a detailed notice in writing of our privacy practices. This notice is available to all patients who ask to read it.

I understand that under HIPAA, I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to:

- Conduct, plan and direct treatment and follow-up among the multiple health providers who may be involved in my treatment, both directly and indirectly.
- Obtain payment from third party payers
- Conduct normal healthcare operations, such as quality assessments and provider certifications.

I acknowledge that I have been given the opportunity, prior to signing this consent, to read Primary and Immediate Care of the Pines' Notice of Privacy Practice, which contained a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it's Notice Of Privacy Practice from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I acknowledge that I may request in writing that you restrict how my private information is used and disclosed to carry out treatment and/or payment of healthcare operations. I also understand that you are not required to agree to my requested restriction(s), but if you agree then you are bound to abide by such restrictions.

I acknowledge that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Authorizations

Please check the specific information you wish to be used or disclosed:

____ Any Medical Information
____ Test Results
____ Lab Work
____ Medication Information
____Procedure Information
____ Office Visits

The following people are authorized to make a request for the information above:

Name:	Relationship:
_____	_____
_____	_____
_____	_____

____DO NOT release any medical information to anyone.

Signature _____ Date _____