Patient Name _____
Date_____

HIGH ROCK INTERNAL MEDICINE, PA PATIENT PAYMENT POLICY

Welcome to High Rock Internal Medicine. As a patient of ours, we strive to provide you with the best medical care possible at the lowest cost. The following information will help us to do this. If you have any questions, please feel free to call our billing department at (336) 224-0931.

The following explains our policies:

- We will ask for your present address and insurance information at each appointment. We will also copy your insurance card at every visit. This is to keep our records current.
- We require a copy of a valid driver's license.
- Copayments are due at check in. If you do not have your copayment your appointment may be rescheduled.
- Deductibles, coinsurance and payments for services not covered by your insurance are due at checkout.
- A parent or legal guardian who signs for the care of a minor patient is responsible for payment of the fees.
- We will file your insurance as a courtesy. All unpaid balances become your responsibility after insurance pays.
- We process all checks electronically and when you pay by check you authorize us to make a one (1) time transfer of funds from your account. Funds may be withdrawn as soon as the same day you make payment.
- Returned checks will be re-presented to the bank and a service fee of $25 will be charged.
- In the event of a voided credit card transaction, the monies will take 5-7 business days to be restored to account.

PLEASE READ AND SIGN BELOW

AUTHORIZATION TO PAY BENEFIT TO PHYSICIAN: I, the undersigned, hereby authorize payment directly to the physician for his/her services. I hereby authorize the physician to release any information acquired in the course of my examination or treatment to specific insurance carriers, third party payers or others involved in processing or collection of this claim.
DATE:_____RESPONSIBLE PARTY:_____

ASSIGNMENT AND RELEASE: I, the undersigned, certify that I (or my dependent) have insurance coverage and have provided that information and assign directly the Physician all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

DATE:_____RESPONSIBLE PARTY:_____

DATE: _____ WITNESS: _____

High Rock Internal Medicine, P.A.
Patient Acknowledgement of Receipt of
Notice of Privacy Practices (NPP)
Version 130905 1139

I, _____ hereby affirm that I have received a copy of the *Notice of Privacy Practices, Version 130905 1139,* from High Rock Internal Medicine, P.A.. Under federal law 104-191, also known as HIPAA, I am entitled to receive a copy of this *Notice* from my healthcare provider.

I understand that my signature on this Acknowledgement only signifies that I have received a copy of the *Notice*, and does not legally bind or obligate me in any way.

I understand that I am entitled to receive a copy of the *Notice of Privacy Practices* from my healthcare provider, whether I sign this Acknowledgement or not.

Patient Name: _____

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority (if applicable)

▼▼▼ FOR OFFICE USE ONLY-Staff Complete Each of the 4 Lines ▼▼▼

Staff received by:	
Date received by staff:	Time Received by staff:
Patient declined ☐ Patient did not decline ☐	If declined, Staff Signature that witnessed the decline. _____
Staff Signature of person setting Practice Advisory for 1 year renewal of NPP Form:	

Designated Party Release

High Rock Internal Medicine, P.A.
104 West Medical Park Drive
(336) 224-0931

You may give **High Rock Internal Medicine, P.A.** written authorization to disclose your protected health information to anyone that you designate, such as a family member or personal representative. If you wish to authorize a person to receive your protected health information, please complete the form below. You may also use this form to give us consent to leave detailed information (results of labs, x-ray, prescription refills, etc.) on your home answering machine, voice mail at work, cell phone, or another party that you designate.

Patient Name: _____Date of Birth: _____

Date: _____ Account # _____Chart #: _____

At my request, I authorize **High Rock Internal Medicine, P.A.** to disclose my protected health information to:

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Name:_____ Phone #: _____

At my request, I also authorize **High Rock Internal Medicine, P.A.** to communicate my protected health information to me via the following methods:

☐Leave detailed message on my home answering machine (phone #: _____)

☐Leave detailed message on my voice mail at work (phone #: _____)

☐Leave detailed message on my cell phone voice mail (phone #: _____)

☐Fax detailed medical information (fax #: _____)

Authorized Signature: _____Date:_____

I understand that I may cancel this authorization at any time by signing this notice below. However, if I cancel this authorization, I also understand that the cancellation will **not** affect any action **High Rock Internal Medicine, P.A.** took in reliance on this authorization before receipt of written notice of cancellation.

Signature Authorizing Cancellation: _____

Date Authorization Cancelled: _____

Patient Registration Form

Date of Appointment: _____

Patient Information

Patient's First Name	Middle Name	Last Name (as it appears on insurance card or ID)

Sex	Marital Status	Date of Birth (Age)	Social Security Number

Patient's Address	City	State	Zip

Home Phone	Mobile Phone	Email Address

Referred by	Primary Care Physician	Primary Care Physician Phone

Pharmacy	Pharmacy Phone	Pharmacy Address

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone

Employer/School Address	City	State	Zip

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Billing and Insurance

Primary Health Insurance

Insurance Company	Plan

Plan Number	Group Number	Insured's Employer/School

Insured's Name (as it appears on insurance card or ID)	Relation to Patient	Insured's Phone Number

Insured's Address	City	State	Zip

Insured's Social Security Number	Insured's Birthdate	

Secondary Health Insurance

Insurance Company	Plan

Plan Number	Group Number	Insured's Employer/School	Insured's Social Security Number

Insured's Name (as it appears on insurance card or ID)	Relation to Patient	Insured's Phone Number

Responsible Party

Billing Name (if other than patient)	Phone	Relation to Patient

Address	City	State	Zip

_____ _____

Signature of Patient or Authorized Guardian Date

Name _____ Gender _____ Age _____

Date of Appointment: _____

Reason for Visit

What brings you to the office today?

How is your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have any other concerns you would like to address?

Current Medications

What medications are you currently taking?

Name	Dosage	Frequency

Allergies

Are you allergic to any of the following?

☐ Adhesive Tape ☐ Antibiotics ☐ Latex
☐ Barbiturates (Sleeping Pills) ☐ Aspirin ☐ Iodine
☐ Codeine ☐ Sulfa ☐ Local Anesthetics

Do you have any other allergies?

Name	Reaction

Past Medical History

☐ Alcoholism ☐ Back Problems ☐ Ear Problems
☐ Allergies ☐ Bleeding Disorder ☐ Eating Disorder
☐ Anemia ☐ Blood Disease ☐ Epilepsy
☐ Anxiety Disorder ☐ Blood Transfusion ☐ Glaucoma
☐ Arthritis ☐ Cancer ☐ Gout
☐ Asthma ☐ Diabetes ☐ Heart Disease
☐ AIDS / HIV ☐ Depression ☐ Heart Problems
☐ Hepatitis - A, B, or C ☐ Measles ☐ Skin Disorder
☐ High Blood Pressure ☐ Migraines ☐ Stomach Ulcer
☐ High Cholesterol ☐ Osteoporosis ☐ Substance Abuse
☐ Joint Disorder ☐ Pneumonia ☐ Thyroid Disorder
☐ Kidney Disorder ☐ Polio ☐ Tuberculosis
☐ Liver Disorder ☐ Rheumatic Fever ☐ Venereal Disease
☐ Lung Disease ☐ Stroke

Hospitalizations & Surgeries

Reason	Date

Women Only:

# of Pregnancies	# of Miscarraiges	# of Abortions	# of Living

Last Pap Smear	Last Mammogram	Birth Control Method

Family History

Has anyone in your family ever had any of the following conditions?

☐ Alcoholism ☐ Cancer ☐ Joint Disorder
☐ Allergies ☐ Depression ☐ Kidney Disease
☐ Alzheimer's ☐ Diabetes ☐ Liver Disorder
☐ Anemia ☐ Epilepsy ☐ Lung Disease
☐ Anxiety ☐ Genetic Disorder ☐ Migraines
☐ Arthritis ☐ Glaucoma ☐ Psychiatric Disorders
☐ Asthma ☐ Heart Disease ☐ Osteoporosis
☐ AIDS/HIV ☐ Hepatitis ☐ Stroke
☐ Bleeding Disorder ☐ High Cholesterol ☐ Substance Abuse
☐ Blood Disorder ☐ High Blood Pressure ☐ Thyroid Disorder

Details: _____

Lifestyle Factors

Are you sexually active?

☐ Yes ☐ No # of partners in past year _____

Do you wish to be checked for STDs?

☐ Yes ☐ No

Has anyone in your home ever physically or verbally hurt you?

☐ Yes ☐ No

Have you ever smoked?

☐ Yes ☐ No # of years _____ # packs/day _____

Do you smoke now?

☐ Yes ☐ No # packs/day _____

Do you use recreational drugs?

☐ Yes ☐ No types? _____ # times/week _____

How much alcohol do you drink per week?

drinks/week _____

How much caffeine do you drink per day?

drinks/day _____

How often do you exercise?

times/week _____

Medical Review of Systems

Click next to any symptom you have experienced recently, or for which you have concerns. Click again if you wish to remove the checkmark. Please print this form out after its complete and bring it with you to your appointment. If you don't understand something, write a question-mark by it on your print out. . Your doctor will discuss any positive responses with you.

Name: _____

Date: _____

General	
	Recent unexpected weight loss
	Chronic Fatigue
	Anemia
	Lack of regular exercise
	Overweight

Eyes	
	Failing Vision
	Eye pain
	Double Vision
	Blurred vision
	Frequent eye infections
	Glaucoma
	Cataracts

Ears, Nose, Mouth	
	Decreased hearing
	Ringing in ear
	Frequent ear infections
	Frequent nose bleeds
	Sinus trouble
	Frequent sore throats
	Prolonged hoarseness
	Tooth or jaw pain

Cardiovascular	
	Chest pain
	Dizzy spells
	Fainting spells
	High blood pressure
	Swollen ankles
	Irregular pulse
	Shortness of breath

Pulmonary	
	Pneumonia / pleurisy
	Bronchitis/chronic cough
	Asthma/wheezing

Gastrointestinal	
	Recent loss of appetite
	Difficulty swallowing
	Heartburn/gastritis
	Persistent nausea/ vomiting
	Chronic abdominal pain
	Gall bladder trouble
	Jaundice (yellow skin)
	Change in appearance of stool
	Diarrhea
	Constipation
	Bloody or very black stools
	Hemorrhoids
	Hernia

Genito-Urinary	
	Frequent urine infections
	Blood in urine
	Kidney Stones
	Painful urination
	Loss of control of urine
	Decrease in flow
	Urination more than 2 times per night
	Any venereal disease in the past? (Herpes, Chlamydia, gonorrhea)

Musculoskeletal	
	Pain in joints
	Pain in muscles
	Recurrent back pains
	Past injury to bones, spine, or joints
	Gout attacks in the past
	Concerned about osteoporosis

Integumentary	
	Skin rashes
	Hives
	Skin moles-black or changing
	Breast mass
	Nipple discharge

Neurologic	
	Frequent headaches
	Tremor/hands shaking
	Muscle weakness
	Numbness/tingling
	Seizures/convulsions
	Difficulty sleeping
	Excessive daytime sleeping
	Memory loss

Psychological	
	Feeling depressed
	Nervous or anxious feeling
	Excessive moodiness
	Difficulty concentrating
	Phobias/unexplained fears
	No pleasure in life anymore

Endocrine	
	Excessive thirst and urination
	Feet and hands numbness/pain
	Low blood sugar problems
	Intolerance to heat or cold

Hematologic / Lymphatic	
	Excessive bruising or bleeding
	Swollen glands-neck, armpit or groin
	Unexplained fever, chills, night sweats

Allergic / Immunologic	
	Hay fever/Allergies
	Getting lots of infections
	Desire HIV discussion

Substance/Chemical Use	
	More than 6 drinks/week
	Use of tobacco products
	Caffeine use
	Over-the-counter medicine / vitamins

Anything else you want your doctor to be aware of?

Women Only	
	Periods Irregular
	Excessive flow/pain
	Hot flashes/night sweats
	Abnormal PAP smear