

Dear Patient:

You can return this packet as well as copies of your insurance cards by fax (828) 322-5485 or mail to 1321 North Center Street, Hickory, NC 28601.

Once the registration packet and **copies of your insurance cards** are received we will mail you your appointment information in the mail.

If the **Patient Information** and **Insurance Information** sections on the Patient Registration Sheet are incomplete and we do not receive a copy of your insurance cards we will be unable to make your appointment. Please make sure to fill out all **highlighted areas** on forms in the registration packet.

The only exception to this would be if you are ***UN-INSURED*** and paying cash for the weight loss program. In that instance, you need to make sure the **Patient Information** section is filled out. We also want you to be informed that you will be expected to pay the initial \$350.00 fee at the time of your lab appointment. Payment will be accepted in cash or credit card only.

Please **review our office policies** listed in this web site before your scheduled appointment.

If you have any questions feel free to give the front desk a call at either office (828)322-3898 for the Hickory location and (828) 728-1998 for the Hudson location.

Office Policies

OFFICE VISITS:

To help us make the most informed decision about your medical care, please bring the following to your appointment.

- 1.) medicine bottles for all medication you are currently taking
- 2.) all medical records pertinent to your exam (stress tests, ultrasounds, radiological reports, etc.)

If you are a new patient an EKG will also be performed during this exam. Please do not wear any lotion on your arms, chest, or legs; it will keep the EKG sensors from sticking to your skin and will interfere with a proper EKG reading. Please arrive 10 minutes before any appointment.

LAB APPOINTMENT:

For the most accurate results we recommend that you don't eat anything for 8-10 hours before your lab appointment. However, we do not recommend you drink several glasses of water, black coffee, or any other unsweetened/diet drink. Your blood draw will be easier if you are hydrated. It is very important that you make this lab appointment. Having your blood work drawn beforehand allows us to discuss the best treatment options during your exam. If you are unable to make your scheduled lab appointment, please call us as soon as you can so we may help you reschedule. If you miss your lab appointment and we don't hear from you, your exam will be cancelled.

FINANCIAL:

Please remember to bring your most current insurance card(s) to your appointment. You will be asked to show them before every appointment. All co-pays, deductibles, and any charges not covered by insurance are due at the time of service.

We accept MasterCard, Visa, cash, and checks. There is a \$25 service charge for returned checks.

If you are going to participate in the weight loss program please be aware that all shots are to be paid for with either cash or credit card. Checks will not be accepted.

CANCELLATIONS:

Our office gives a reminder call 48 hours in advance of your scheduled appointment.

If you need to cancel or reschedule your appointment, please give a 24 hour notice. This will allow sick patients to be seen. There is a \$50 charge for unkept appointments.

PRESCRIPTION REFILLS:

When you need a refill of a medication that has been previously prescribed for you, please call your pharmacy and have them fax a refill request to our office at (828) 728-2930. We can then fax them a prescription. Do not wait until you are down to your last pill; allow 24 hours for the prescription order to go through. New prescriptions typically require an appointment in order to evaluate the appropriateness of the medication for you. However, narcotics will never be prescribed or refilled after office hours or on weekends.

TELEPHONE:

Every attempt is made to take care of each patient's needs during the same business day you call. Please make sure to give us a contact number for yourself as well as the number of your pharmacy in case a prescription needs to be called in for you.

EMERGENCIES:

After hours, please call the Frye Regional Medical Center operator at (828) 322-6070. Providers from our staff are on call 24-hours a day.

PATIENT ACCESS TO MEDICAL RECORDS

Medical records are confidential documents and will only be released when permitted by law or with proper written authorization by the patient. Physicians are responsible for safeguarding and protecting the medical records and for providing adequate security measures.

Medical records will be copied for transfer to another physician at no cost to the patient the first time they are requested. For any additional requests there will be a reasonable fee for the preparation and/or photocopying of medical records.

Records will either be faxed to the new physician's office or they can be signed for and picked up at our office by the patient or approved family member. We will not mail complete medical records.

PATIENT REGISTRATION

PATIENT INFORMATION

| | | | |
|------------------|----------------|------------------------|---------|
| [REDACTED] | | | |
| TITLE | LAST NAME | FIRST NAME | MI |
| [REDACTED] | | | |
| MAILING ADDRESS | CITY | STATE | ZIPCODE |
| [REDACTED] | | | |
| BIRTHDAY (M/D/Y) | SEX (M/F) | SOCIAL SECURITY NUMBER | |
| [REDACTED] | | | |
| EMPLOYMENT | OCCUPATION | NAME OF EMPLOYER | |
| [REDACTED] | | | |
| STUDENT | NAME OF SCHOOL | | |

INSURANCE INFORMATION

| | | |
|---------------------|-------------------------|---------------------|
| [REDACTED] | | |
| PRIMARY INSURANCE | INSURED'S NAME | INSURED'S BIRTHDATE |
| [REDACTED] | | |
| INSURED'S EMPLOYER | RELATIONSHIP TO PATIENT | INSURED'S SS # |
| [REDACTED] | | |
| SECONDARY INSURANCE | INSURED'S NAME | INSURED'S BIRTHDATE |
| [REDACTED] | | |
| INSURED'S EMPLOYER | RELATIONSHIP TO PATIENT | INSURED'S SS# |

REFERRAL INFORMATION

How did you hear of our clinic? **Yellow pages** **Newspaper** **Internet**

Friend or Healthcare Provider: [REDACTED]

ASSIGNMENT OF BENEFITS FINANCIAL AGREEMENT

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Foothills Internal Medicine, and any assisting medical provider for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further understand that any sums due me if less than \$50.00 will be credited to my medical account. I agree that a photocopy of this agreement shall be as valid as the original.

I have read and understand all of the above and have given truthful information to the best of my knowledge.

| | |
|------------|------|
| [REDACTED] | |
| Patient | Date |

CONTACT INFORMATION

It may be necessary to communicate with you regarding a change in your appointment, instructions, and other information regarding your treatment. In the event we are unable to reach you personally, please give us instructions regarding the best way to communicate with you. Please **check all that apply** and **complete the necessary information**:

- Message may be left on my HOME answering for me at work machine.

My HOME number is _____

- Message may be left for me at my WORK voicemail or with a co-worker.

My WORK number is _____

- Messages may be communicated via EMAIL.

My EMAIL address is _____

- Message may be left on my CELL PHONE.

My CELL PHONE number is _____

- Messages may be left for me with my partner. His/Her name and number is

Other persons authorized to receive information on my behalf and to be considered my EMERGENCY contact are:

| | | | |
|-------|--------|-------|--------|
| _____ | or | _____ | |
| Name | Number | Name | Number |

I hereby release, discharge and agree to hold harmless all parties whom the consent is given from any liability that may arise from the release of information to those authorized above. I realize that I may revoke this consent in writing in the future.

| | |
|-------------------|-------|
| _____ | _____ |
| Patient Signature | Date |

Medication List

Preferred Pharmacy: _____

Phone Number

Allergies to medication (X-ray dyes, drugs):

Example:

Name of medication: Aspirin

Dose or strength of medication: 500 mg

Directions: take one by mouth daily

1. Name of medication: _____
Dose or strength of medication: _____
Directions: _____
2. Name of medication: _____
Dose or strength of medication: _____
Directions: _____
3. Name of medication: _____
Dose or strength of medication: _____
Directions: _____
4. Name of medication: _____
Dose or strength of medication: _____
Directions: _____
5. Name of medication: _____
Dose or strength of medication: _____
Directions: _____

**PLEASE REMEMBER TO BRING ALL OF YOUR
MEDICATION BOTTLES (EVEN THOSE FROM OTHER
PHYSICIANS) TO ALL OF YOUR APPOINTMENTS**

FOOTHILLS INTERNAL MEDICINE, PLLC

Consent Form

PATIENT _____ DOB ____/____/____

Consent for Treatment:

I hereby give consent to Foothills Internal Medicine to provide whatever treatment the physician/provider may deem necessary to the patient.

Consent for Insurance Billing:

Foothills Internal Medicine will submit claims to the insurance companies that they are contracted with. I understand that I am responsible for all deductibles, copays, and charges not covered by insurance at the time of service. I also understand that I will need to bring my current insurance card(s) to each visit along with whatever my copay or coinsurance is.

Acknowledgment of Unkept Appointment Policy:

Foothills Internal Medicine gives a reminder call 48 hours in advance of scheduled appointments. If you need to cancel or reschedule we ask that you give us 24 hours notice. If we do not have adequate notice we are unable to fill the appointment slot that we had reserved for you. There is a \$50 charge for all unkept provider appointments.

Authorization to Release Information:

I hereby authorize Foothills Internal Medicine to release any information acquired in the course of my treatment to any insurance company including Medicare. I also authorize the payment of claims directly to Foothills Internal Medicine.

Signature for treatment, insurance policy, and authorization to release information:

SIGNED _____ Date _____

Acknowledgement of Receipt of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. It also provides information about your rights as a patient of our practice and whom you may contact at our practice to ask questions about our privacy practices. By signing this form, you have agreed that you have had the opportunity to read our Notice of Privacy Practices.

Foothills Internal Medicine

1321 North Center Street
Hickory, NC 28601
OFFICE (828) 322-3898 FAX (828) 322-5485

286 Pine Mountain Road
Hudson, NC 28638
OFFICE (828) 728-1998 FAX (828) 728-1996

JENNIFER WOODSTOCK, PA-C

GERRI MORRISON, FNP-BC

Medical Records Release

I, _____, request my medical records including current and previous records, which are part of my medical background be released to ***Foothills Internal Medicine.***

Persons Authorized to Disclose Information

(WHERE RECORDS ARE COMING FROM)

Provider's name: _____

Facility: _____

Address: _____

Telephone: _____ Fax: _____

Patient Authorizing Release

Patients Name: _____

Social Security Number: _____ DOB: _____

Other Names Used In The Past: _____

This authorization is effective for one year unless revoked or terminated by the patient.

Patient Signature: _____

♥Help Foothills Internal Medicine take care of you ♥

Name: _____
(Patient) _____ (Date)

Do you have any moles, skin tags or warts that you want removed? YES NO

When was your last complete physical exam? _____
(a complete physical should include an EKG, labs and if you are female; a pelvic exam)

Are you interested in losing weight? YES NO

Do you have problems sleeping? YES NO

Do you need help to stop smoking or drinking alcohol? YES NO

Are you interested in Botox or Juvederm? YES NO

Are there any other cosmetic procedures that you are interested in? (like sclerotherapy-removal of varicose or spider veins, cellulite removal, acne therapies)

If so, what? _____

What other health care providers do you see? (list providers name and specialty)

1. _____
2. _____
3. _____

Listed below is the **standard of care** you should be receiving for your age group. Please review and discuss with your health care provider.

If you are Ages 18-30: (check off testing you would like to discuss)

- Have you had your cholesterol and triglycerides checked **every 5 years**?
- Have you had a dental exam **every 1 to 3 years**?
- Have you had an eye exam **every 1 to 3 years**?
- Female: Have you had a clinical breast exam **every year**?
- Female: Have you had a pelvic exam and pap smear **every year**?
- Female: Are you at risk for sexually transmitted diseases?
- Have you had Chlamydia testing?
- PLEASE LOOK AT LIST OF IMMUNIZATIONS ON THE BACK OF THIS PAGE.**

If you are Ages 30-64: (check off the testing you would like to discuss)

- Have you had your cholesterol **checked yearly**?
- Have you had a digital rectal exam **yearly since 40 years old**?
- Have you had a fecal occult blood test **yearly since 40 years old**?
- Have you had a colonoscopy at age **50 years and every 10 years thereafter if normal**?
- Have you had a dental exam **every 6-12 months**?
- Have you had an eye exam **every 2-4 years**?
- Do you have problems with your balance or dizziness?
- Male: Have you had a **yearly** prostate specific antigen and prostate exam since being 40 years old?
- Male: Have you had a testosterone test done?
- Female: Have you had a **yearly** clinical breast exam?
- Female: Have you had a **yearly** mammogram since being 40 years old?
- Female: Have you had a **yearly** pelvic exam and pap smear?
- Female: Is menopause affecting you?

If you are Ages 65 and over: (check off testing you would like to discuss)

- Have you had a **yearly** hearing test?
- Have you had a **yearly** fecal occult blood test?
- Have you had a colonoscopy **every 10 years**?
- Have you had **yearly** cholesterol levels?
- Have you had a dental exam every **6-12 months**?
- Have you had a **yearly** eye exam?
- Do you have problems with your balance or dizziness?
- Female: Have you had a yearly mammogram until age 75 if normal?
- Female: Have you had a clinical breast exam until age 75 if normal?
- Female: Have you had a bone density test **yearly**?
- Male: Have you had a **yearly** prostate specific antigen test?
- Male: Have you had a testosterone test done?

Have you had your immunizations? (check off the vaccines you would like to discuss)

- Tetanus-diphtheria booster-once, between ages 14-16 and then a booster **every 10 years**
- Influenza vaccine **yearly**
- Pneumococcal vaccine-**once**, everyone **over 65**; and for below age 65 for medical or other indications
- Measles, mumps, rubella (MMR) or varicella (chicken pox)-1-2 doses, for persons without proof of immunity with occupational or other indications. Once, for women of childbearing age without proof of rubella immunity.
- Hepatitis A and hepatitis B vaccines-**once**, for persons in health care occupations or working with blood, intravenous drug users, those having multiple sexual partners or having sex with a hepatitis-infected person.
- Meningococcal (polysaccharide)-**once**, for persons with medical indications or other specific indications.

Hickory Office

1321 North Center Street
Hickory, NC 28601
Phone: 828-322-3898
Fax: 828-322-5485



www.foothillsinternalmed.com

Hudson Office

286 Pine Mountain Road
Hudson, NC 28638
Phone: 828-728-1998
Fax: 828-728-1996

FAMILY HISTORY

Date: ____/____/____

Name: _____

Current problem: _____

Family History: Age / Major Illness

Mother _____

Father _____

Brothers _____

Sisters _____

Grandparents _____

Social History: M S D W

Occupation _____

Children (ages) _____

Tobacco: Y N Coffee: Y N Alcohol: Y N

Exposure to Industrial Fumes? Y N

Past Medical History: (check if possible)

- ___ High Blood Pressure
- ___ Diabetes
- ___ Protein or Blood in Urine
- ___ Kidney Disease
- ___ Kidney Stones
- ___ Liver Disease
- ___ Chest Pain
- ___ Heart Attack
- ___ Arrhythmias
- ___ Thyroid Disease
- ___ High Cholesterol
- ___ Stroke
- ___ Arthritis
- ___ Phlebitis
- ___ Lung Problems, Disease
- ___ Cancer, Abnormal Mammogram
- ___ TB
- ___ Weight Loss/Gain
- ___ Diverticulosis, Blood in Stool
- ___ Migraine Headache
- ___ Ulcers
- ___ Skin Disease, Rash
- ___ Hiatal Hernia
- ___ Depression or Anxiety
- ___ Gout
- ___ Anemia
- ___ Seizures
- ___ Vasculitis
- ___ Abnormal Pap Smears
- ___ Erection Difficulties
- ___ Sexual Difficulties

Review Symptoms: (check if possible)

- General:**
- ___ weight change/year
 - ___ appetite change
 - ___ fatigue/malaise
- Head:**
- ___ headaches
 - ___ eyes, vision
 - ___ ears, hearing
 - ___ nose
 - ___ throat, swallowing
- Neck:**
- ___ swelling
 - ___ tenderness
- Chest:**
- ___ pain
 - ___ pressure
- Breasts:**
- ___ tenderness
 - ___ lumps
- Lungs:**
- ___ wheezing
 - ___ chronic cough
 - ___ shortness of breath
- GU (urinary):**
- ___ pain
 - ___ frequency
 - ___ blood
 - ___ erectile dysfunction

- Bones:**
- ___ gout
 - ___ joint pain
 - ___ swelling
- GYN:**
- ___ LMP _____
 - ___ # pregnancies
 - ___ # children
- Neuro:**
- ___ numbness
 - ___ tingling
 - ___ weakness
 - ___ dizziness
 - ___ fainting
- Extremities:**
- ___ swelling, edema
 - ___ coolness, blue color
 - ___ painful calves when walking
- Skin:**
- ___ rashes, lesions, unusual moles
- GI (digestive):**
- ___ abdominal pain
 - ___ nausea, vomiting
 - ___ black tarry stool
 - ___ red blood in stool
 - ___ constipation

Surgeries: Procedure / Date / Surgeon

Hospitalizations: Location / Date / Problem

Screening tool for Sleep Apnea

Developed by David White, M.D., Harvard Medical School, Boston, MA

Patient Name: _____ DOB: _____ Date: _____

1. Snoring:

a) Do you snore on most nights (>3 nights per week)?

Yes (2) No (0) _____

b) Is your snoring loud? Can it be heard through a door or wall?

Yes (2) No (0) _____

2. Has it ever been reported to you that you stop breathing or gasp during sleep?

Never (0) Occasionally (3) Frequently (5) _____

3. What is your collar size?

Male: Less than 17 inches (0) More than 17 inches (5) _____

Female: Less than 16 inches (0) More than 17 inches (5) _____

4. Do you occasionally fall asleep during the day?

a) You are busy or active?

Yes (2) No (0) _____

b) You are driving or stopped at a light?

Yes (2) No (0) _____

5. Have you had or are you being treated for high blood pressure?

Yes (1) No (0) _____

TOTAL _____

Self Assessment for Breathing Problems

If you are having breathing difficulties, complete this questionnaire. If for some or all of these and symptoms of emphysema, chronic bronchitis, and COPD fit you, a pulmonary function test upon check out. The earlier COPD is diagnosed, the more effective treatment will be.

Do you experience sever shortness of breath when you exercise or climb the stairs?

Yes

No

Do you have a persistent cough that has lasted for more than a month?

Yes

No

Have you noticed an increase in sputum production, thicker sputum, or a change in sputum color?

Yes

No

Do you have risk factors like smoking or family members with COPD?

Yes

No

Do you have problems sleeping?

Yes

No

Do you sleep better while sitting up?

Yes

No

Have you had an unexplained increase or decrease in weight?

Yes

No

Do you feel more tired and have less energy than usual?

Yes

No