Summer FamilyCare

Information for new patients to our practice: WELCOME!

1. **Same-day Appointments.**
We will always reserve some space each day for "same-day" appointments, but please call as early as possible. We cannot guarantee that you will be seen that day if we are already full, but will make every effort we can. We **will** always see your sick children that same day as a rule.

2. **Refills**
Please ask your pharmacy to send us a refill request, and give us 24-48 hours to process it. We will usually get to it sooner, but give us a little time. If it is urgent, please call us first. We will not do refills after hours for any controlled medication (pain medication, etc.).

3. **Physicals**
Please call to make an appointment. There are often lab tests that we can do ahead of time so the results will be ready when you come for your exam.

4. **If You Need to be Hospitalized**:
I have arranged for in-hospital physicians at Forsyth Medical Center to care of our patients that need to be treated in the hospital at Forsyth Medical Center. I communicate closely with these doctors who work only in the hospital. We do not restrict patients from going to any hospital or specialist they prefer.

5. **X-rays**
Yes, we can do most regular X-rays here in the office.

6. **After-Hours Needs**
I have registered nurses who are available after office hours for medical advice. Just call the regular office number and you will automatically be connected to the answering service and then the nurse on duty. They will contact me if you need to speak to me directly. Of course, if it is an emergency, please call 911. Local Urgent Care clinics are a reasonable option for things that cannot wait. We do not support clinics inside pharmacies for several reasons.

7. **Payments**
We ask that you have your standard insurance co-pay ready when you check in. Your policy requires that the co-pay be collected at the visit, not later. The contact number for our billing service should be on your statements.

8. **Missed appointments**
We ask that you give us notice if will not be able to keep a scheduled appointment, at least 24 hours. If you miss an appointment without notice, there may be a charge. We will not be able to schedule after repeated missed appointments.

9. Appointment Times
Your appointment time only guarantees that we have reserved space that day for you. We just cannot guarantee that you will be seen at that exact time. We do the best we can to be timely, but sometimes issues require more time than expected and you may have to wait a bit. Just remember that it may be you that requires that extra time some day.

10. Phone calls
Most of my time during the day is spent with patients in the office. As a general rule, I do not have much chance to communicate with patients by phone personally. If you need my input about a medical issue, please schedule an office visit. If it is a simple question, my staff can help you, or will ask me and get back to you.

Dr. Summer

Summer FamilyCare

How often do I need to see the doctor????

To meet our recommendations to best treat certain common conditions, you will be expected to follow the schedules listed below. While this may not apply to every single case, it is a good baseline to follow. Yes, if you have more than one condition, you will need to come in at the shorter time, not the longer:

Reason/condition	**How often?**	**Visit type**
Any ongoing prescription	at least once a year	Doctor visit, No Rx is valid more than a year (6 months visits are required for any controlled substance prescriptions)

Cholesterol medication	Yearly (if controlled)	Blood test, Doctor visit
---		
High Blood Pressure	6mo	Blood test, Doctor visit

Diabetes	3-4mo	Blood test, Doctor visit (may be extended if very well-controlled)

_____

Recommended Physicals (Otherwise known as Preventive Health visits)

These are visits to evaluate your current health status and recommendations, depending on your age, family history, etc., for additional testing or treatment to PREVENT problems. These type of things include screenings for colon, prostate, skin, and breast cancer; diabetes, high blood pressure, cholesterol and to discuss vaccines for tetanus, whooping cough, shingles, meningitis, etc… Also, we may find problems that may already exist BEFORE they cause big problems. ("My blood pressure/sugar/cholesterol, etc. is what?)

These visits can often be combined with a regular visit for other reasons (see above) but, if the ongoing conditions are multiple or complicated, there may be extra fees. (For example: a yearly check for cholesterol treatment can be done during a physical)

A yearly physical is always a good idea, and -if scheduled around your birthday- easy to remember. If you use your insurance for this, check how often they cover physicals, but remember: they are not always the best guide for what is best for YOU. Here is our recommended minimum best frequency:

Age	How often?
2-18	Yearly (monitoring growth, development, etc.)
18-40	2-3y (if in reasonably good health)
40+	Yearly (again…new recommended screening tests added as you get wiser)

Summer FamilyCare

PATIENT INFORMATION

Last Name_____ First Name_____ Middle Name_____
Preferred Name (Nickname) _____

Address _____City_____ State _____Zip _____

DOB _____/ _____ /_____ SSN _____-_____-_____ Marital Status_____ Sex _____

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____ Cell Phone (_____) _____ -_____

Email Address _____

Employer Name and Phone Number _____Occupation _____

Emergency Contact
Name_____ Address_____
Relationship _____
Home Phone _____Work Phone_____ Cell Phone _____

INSURANCE INFORMATION

Primary Insurance Company _____ Plan Name / Type _____
Co Address _____City _____ State _____ Zip _____

Employer_____ Group Number _____ Policy Number _____

Policy Holder Name _____ Relation to patient _____

SSN of Policy Holder _____ Policy Holder's DOB _____

Secondary Insurance Company _____ Plan Name / Type _____
Co Address _____City _____ State _____ Zip _____

Group Number _____ Policy Number _____

Policy Holder Name _____ Relation to patient _____

SSN of Policy Holder _____ Policy Holder's DOB ____ _____

Summer FamilyCare will gladly submit your bill to your insurance company as a courtesy to you, however if we haven't received a response from them within 30 days of the billed date this bill will become your responsibility. All co pays and co insurance are due at time of service.

Patient or Responsible Party Signature_____ Date_____

Summer FamilyCare New Patient Information

Patient Name:_____ Date: _____
Person filling out form, and relationship to patient:_____

Please list all Medications you take, **including vitamins and supplements:** (if you have a list, let us make a copy)

Medicine name and dose (mg)	Times per day	Reason for medicine	When did you start it?

Your preferred pharmacy:_____

Please list any **Medication ALLERGY** below:

ALLERGY	REACTION

Are you allergic to LATEX? YES NO (circle one)

Medical History
Do you have, or have you had, any of the following conditions? (Circle YES or NO):
High Blood Pressure YES NO **Diabetes** YES NO **High Cholesterol** YES NO

Cancer YES NO if yes, please explain_____

Depression YES NO **Arthritis** YES NO **Chronic Pain** YES NO if yes, where? _____

Mental Health Condition YES NO Please explain_____

Heart Problems YES NO if yes, please explain_____

Lung Problems YES NO if yes, please explain_____

Stomach/Intestinal Problems YES NO if yes, please explain_____
Any Other Medical Problem: if yes, please explain_____
_____
_____

Have you had **Chicken Pox, or the vaccine**? YES NO (Please state which)_____ _____
When was your last **tetanus booster**? (If over age 11)_____
Have you ever had a **blood transfusion**? YES NO If yes, when and why? _____

Patient Name:_____

Have you had ANY **Surgery** of any type? If so, please list below.

Check if you have had: Date (year)
( ) Appendectomy _____
( ) Hysterectomy _____
( ) Gall Bladder removed _____
( ) Tonsils removed _____

Other operations:

Date	Surgery	Reason	Comment

Any **Hospitalizations** other than those above? YES NO
If YES, please explain
_____
_____

Family History	Living, Yes/No	If living, Date of Birth	Any medical problems?	If deceased, at what age?	Cause of death?
Father					
Mother					
Sister					
Brother					
Other siblings					
Children					

Are there any other conditions that seem to run in the family? If so, please explain:
Heart problems?_____
Cancer of any sort?_____
Diabetes_____
Other?_____
_____
_____

Do you see any other doctors on a regular basis (OB-GYN, Cardiologist, etc.)? If so, please list their name(s) and the reason for treatment, and initial if you give permission for us to send information:
_____Init_____
_____Init_____
_____Init_____

Patient Name: _____

Are you: Married Single Divorced Separated Widowed
Who lives with you at home?_____
Do you have a Living Will or Advanced Directive? YES NO

Do you smoke? YES NO If you smoke cigarettes, how many packs per day? ____
For how many years? ___

Are you interested in quitting? YES NO

Do you exercise? YES NO If yes, what form?_____ How many times per week? _____

Do you drink alcohol in any form? YES NO If yes, how much in one week?_____

Do you use, or have you used, recreational drugs? YES NO In the past: what?_____
If you currently use recreational drugs, what?_____ Any injected drug use? YES NO

If you are over the age of 50, have you had a screening colonoscopy? _____
If yes, when and where was it performed _____

Are you exposed to hazardous chemicals at work? YES NO if yes, explain_____

For Children:

Attend daycare: YES NO

Up to date on immunizations? YES NO Please provide a copy of shot records, as soon as possible.

Any reactions to past shots? YES NO If yes, please explain_____

Ladies Only
Age when you first had your period? _____ Are your periods regular? _____ if no, please explain
_____
Have you gone through menopause? YES NO If yes, at what age? _____
Did you take hormone replacement? YES NO if YES, for how long? _____
Do you use contraception? YES NO If YES, what form? _____
When was your last Pap smear/ Well Woman Exam? _____
Have you ever had an abnormal Pap smear test? YES NO if "yes" please explain_____
Obstetrical history:
Have you EVER been pregnant? YES NO If yes, how many times? _____
How many deliveries/births? _____ any problems? _____
_____

If you are over 40, when was your last mammogram? _____ Was it normal? YES NO
If not, please explain_____
Any family member with breast cancer, or breast disease? _____

Do you have any concern for your safety at home? _____

Some useful information about insurance, our charges, and your bill:

The world of health insurance is complicated and confusing. Here are some explanations of a few important topics that apply to how much you pay for medical care.

What exactly is a "co-pay"?

If you have a co-payment (co-pay), this is set by your insurance company. Your insurance company pays us a set amount for a specific service, and the co-pay is subtracted from this amount. It is your portion of the total payment.

***Your co-pay is not an added payment for us**.*

We are not allowed, by your insurance company's rules, to change or reduce the co-pay amount. If you co-pay increases, it means your insurance company has decreased how much they pay us by the same amount. We are required to collect the co-pay at the visit.

What is "co insurance"?

In some cases, instead of co-pay, your insurance company states that you must pay a percentage of the charges. In this case, the amount will depend on the particular service.

Preventive Health services

Some insurance plans do not pay for preventive services, such as physicals, vaccinations, or blood tests such as cholesterol levels. It is the patient's responsibility to check if the services are covered. **If the services you want are not covered, you will be responsible for the charges.**

Deductibles

More and more, insurance policies have included a "deductible" in your insurance coverage. A deductible is a set amount that your insurance company requires you to pay first before they will start to pay for any services. Usually, this is a yearly arrangement which means it starts over every year. If you have not paid this amount yet, you are responsible for the full charge until you have.

We have no control over the amount of your deductible, or your charges. This is decided solely by your insurance policy.

If you have questions regarding your bill, co-pay, or deductible please contact your insurance company, or your employer's Human Resources department. As I have outlined above, they tell us what your charges will be. We do not have any control over your bill.

This information does not apply to "self-pay", or those patients who do not have insurance. These charges are due in full on the day of the service.

Summer FamilyCare

Authorization to Use or Disclose Health Information
(Request for Medical Records)

Patient Name: _____ **Date of Birth:** _____
Please print full name

1. I authorize the use or disclosure of the above named individual's health information by Summer FamilyCare.

2. Previous Doctor or Practice Name:_____

   Address: _____

   Phone #_____

3. I understand that the information in my health record may include information relating to sexually transmitted disease, HIV/AIDS, behavioral or mental health services or alcohol and drug abuse.

4. The information identified above may be used or disclosed to the following individual(s) or organization(s), and please **mail** records to:

   Summer FamilyCare
   6614 Shallowford Road, Ste. 100
   Lewisville, NC 27023
   Ph: (336) 945-0277 Fax: (336) 945-0213
   (if limited, specific information requested , may fax to above number)

5. This information for which I am authorizing disclosure will be used for the following purpose:
   □ Transferring Primary Care
   □ My personal use
   □ Sharing with other health care providers
   □ Other: _____

   Records requested: □ Progress Notes □ Imaging/Lab Results □ Consult Notes

   □ All Records, □ Specific information: _____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

7. This authorization will expire on _____. If I fail to specify an expiration date, this authorization will expire in six months from the date of this authorization.

8. I understand that once the above information is disclosed, it may be redisclosed by the recipient, and the information may not be protected by the federal privacy laws or regulations.

9. I understand the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure access to medical treatment.

10. I understand that there may be a charge billed to me from the office sending the records. The amount of this fee, if any, is solely determined by the sender, **NOT** by Summer FamilyCare.

_____ _____
Signature of patient or legal representative Date

If legal representative, name and relationship to patient:_____

_____ _____
Signature of witness Date

Charge for failing to keep a scheduled appointment. There will be a minimum charge of $25.00 for failure to keep a scheduled appointment if you have not notified our office at least 24 hours in advance of the appointment date. The charge will be assessed after the 2nd failed appointment.

Payment Arrangements: We will work with you to make arrangements for payment for your portion of your account balance. Please speak to the office staff or the Billing Office to discuss payment arrangements. If your account is delinquent for more than 90 days or you have failed to made regular payments on your account, your account may be turned over to collections.

ASSIGNMENT OF BENEFITS and RELEASE OF PERSONAL HEALTH INFORMATION

Assignment of Benefits: I authorize direct payment of benefits to my attending physician or to whomever the physician designates. I understand that I am personally responsible for charges not covered by my insurance policy, including charges for healthcare services determined to be not medically necessary by my insurer's utilization review program.

Authorization for Release of Personal Health Information: I authorize the practice and the patient's attending physician to disclose any medical information currently existing or developed during the course of treatment from the patient's medical record to (1) the referring physician, a health care facility or a physician to which the patient may be referred; (2) a representative of (a) any party financially responsible for the patent's care, (b) any regulatory agencies if required by law, and (c) any additional person listed below whom the patient or their designee authorizes to receive information about the patient's care and treatment:

_____ (person) _____ (relationship)

_____ (person) _____ (relationship)

ACKNOWLEDGEMENT AND ACCEPTANCE:

- **I did read and do understand the practice's Financial Responsibility Policy.**
- **I did read and do understand the Assignment of Benefits and Authorization for Release of my PHI.**
- **I agree to comply with both policies.**
- **I understand if I have any questions I can speak with the office staff, office manager or my physician.**

Patient Name: _____

_____ (SEAL) _____/____/_____
Signature of patient or guarantor Date

Financial Responsibility Policy
[Consent for Assignment of Benefits & Release of Records for Billing]
Summer FamilyCare

Purpose: This financial policy is used to inform our patients about their financial responsibilities for services received at our practice. Please ask any questions you might have to our staff or manager.

Insurance and demographic information: We maintain a copy of your most current insurance card and contact information on file. Please alert our staff about any changes to your insurance coverage (sponsor and plan) or contact information (your name, address, and contact information). Some changes will require a new patient insurance information form. If the insurance information provided is incorrect and your claim for service is denied, you will be responsible for the entire amount of the service. We will provide you the claim data if you wish to it submit to your insurer to seek reimbursement for your out-of-pocket costs.

Payments required at time of service: You are expected to make any co-payments and/or pay for deductibles prior to each office visit. If you do not have insurance, you will be required to pay the full amount due at each visit or make prior arrangements to meet your financial obligations for receiving services. Patients with high deductible health plans (HDHP) or those paying with a check or debit card from a health savings account (HSA) or a health reimbursement account (HRA) should expect to pay all balances for their services until annual deductibles are met.

Forms of payment: Cash, checks, money order, cashiers check, most credit cards, and debit cards.

Patient is personally responsible for any charge: We will file a claim with your insurance carrier. Your policy is a contract between you and your insurer. We are not a party to the contract. We will assist you to get the full benefit of your insurance but you retain the final responsibility for the charges.

Office policy on insurance assignment: We will contact your insurer to verify that you have coverage for the services, treatments and procedures before your appointment and to ensure that your coverage is active. We will file a claim to your insurance company on your behalf. However, if your insurer fails to pay the claim, you are responsible for any unpaid balance on your account. If our practice is not a participating provider in your insurer's network, you will be notified before your visit and you will be responsible for payment in full or for the estimated amount that will not be covered for out-of-network benefits. You are expected to annually update your assignment of insurance benefits form which permits us to bill your insurance plan and to release medical information to your insurance company for payment and treatment.

Fees due if your account is sent to collections: You are responsible for any fees and/or attorney fees related to collecting an outstanding balance in your account. Collection fees may be up to 35% of the amount due in addition to your balance. If your account remains in arrears, you may be dismissed from the practice.

Referrals to other Specialists or Providers: If you are referred to another provider for treatment, testing, or for other care, please understand that you will be billed separately by that provider and/or facility. You are responsible to check that provider is on your insurance network. You may call your insurer to get a list of providers that participate in your network and we will refer you to a different provider.

Charge for insufficient funds check: There will be a minimum charge of $25.00 for each check that is returned for insufficient funds. The charge must be paid before the patient is seen again. After the first returned check, no checks will be accepted during the next 6 months. After a second check is returned, we will not accept checks for any future services.