TABLE ROCK
FAMILY MEDICINE
301 LINVILLE STREET
P.O. BOX 837
GLEN ALPINE, NC 28628

RECORDS RELEASE FORM

I, ______________________________, authorize Table Rock Family Medicine to obtain and / or release my medical information from / to the persons listed below. I understand and agree that my medical records may be release by facsimile (fax) if necessary.

Send records to:

Name: ____
Address: ____

Name: ____
Address: ____

Obtain records from:

Name: ____
Address: ____

Name: ____
Address: ____

Release records to:

Name: ____
Address: ____

Name: ____
Address: ____

____
Signature of Patient   Date of Birth   Home Address

____
Signature of Guardian/Parent   Relationship to Patient   Date

It is understood that the above information to be released to Table Rock Family Medicine, PLLC is fully protected by the laws establishing the confidentiality of information acquired by Table Rock Family Medicine, PLLC.

Authorization must be signed both by the patient and the nearest relative/guardian if the patient is under 18 years of age or by the nearest relative/guardian if the patient is incompetent or otherwise incapacitated.

BLUE RIDGE
HEALTHCARE

Name: ______________________________ **Date:** ______________ **DOB:** ________________

☐ NO ☐ YES HAVE YOU HAD ANY HOSPITALIZATIONS/ SURGERIES/ ILLNESSES **IN THE PAST YEAR**? (IF YES, EXPLAIN IN SPACE BELOW)

ALLERGIES ☐ None ☐ Latex ☐ Codeine ☐ Morphine ☐ Penicillin ☐ Sulfa ☐ Iodine ☐ Aspirin ☐ Foods ☐ Bee Stings ☐ OTHER

MEDICATIONS: Please bring all medication bottles with you to your visit. This includes all OTC medications

PREVIOUS SURGERIES or PROCEDURES **(indicate approximate date)**

☐ Appendectomy	☐ Laparoscopy	☐ Obesity Surgery (gastric bypass)
☐ Colonoscopy ____________(yr)	☐ Tubal ligation	☐ Lithotripsy (kidney stone)
☐ Gallbladder	☐ Hysteroscopy	☐ Orthopedic surgery (Back, knee, hip, etc)
☐ Tonsillectomy	☐ Endometrial ablation	☐ Thyroid surgery
☐ Dental	☐ Hysterectomy, partial or total	☐ Sinus surgery
☐ Breast	☐ Ovaries- removal of one or both ovaries	☐ Heart Surgery
☐ Cosmetic surgery	☐ Urethral stretching	☐ Hernia repair
☐ D & C	☐ Bladder surgery	☐ Hemorrhoid surgery

LIST ALL OTHER SURGERIES OR HOSPITALIZATIONS

MEDICAL HISTORY (indicate whether you have had any of the following medical problems **with approximate date of diagnosis**)

☐ Anemia	☐ Colon polyps	☐ Heart Attack	☐ Rheumatoid Arthritis
☐ Anesthesia problems	☐ Crohn's Disease	☐ Heart Murmur	☐ Reflux (GERD)
☐ Anxiety Disorder	☐ Celiac Disease	☐ Hearing problems	☐ Sleep Apnea
☐ Asthma	☐ Depression requiring counseling or medication	☐ Hepatitis (A, B, C, other)	☐ Schizophrenia
☐ Attention Deficit Disorder		☐ High Cholesterol	☐ Skin Disorder
☐ Allergies	☐ Depression, postpartum	☐ High blood pressure	☐ Stroke
☐ Bipolar Disorder		☐ Irritable Bowel Syndrome	☐ Stomach Ulcer
☐ Blood Clot in legs/lungs	☐ Diabetes	☐ Kidney Disease	☐ Thyroid Disorder
☐ Blood Transfusion	☐ Epilepsy (seizures)	☐ Kidney Stones	☐ Tuberculosis
☐ Cancer of any type	☐ Glaucoma	☐ Lupus	☐ Varicose Veins
☐ Chemical dependence or substance abuse	☐ Headaches, chronic	☐ Mitral valve prolapse	☐ Weight Problems – Obesity
	☐ Headaches , migraine	☐ Osteoarthritis	☐
☐ Chronic Pain requiring treatment		☐ Osteoporosis	
☐ Chronic Fatigue Syndrome			

Marital Status ☐ Single ☐ Separated ☐ Married ☐ Divorced ☐ Widowed

FAMILY HISTORY ☐ **I was adopted** ☐ **I do not know my family history**

	Mother	Father	Child(ren)	Sister(s)	Brother(s)	Aunt/Uncle	Grandparents
Breast cancer	☐	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐	☐
Ovarian cancer	☐	☐	☐	☐	☐	☐	☐
Uterine cancer	☐	☐	☐	☐	☐	☐	☐
Cervical cancer	☐	☐	☐	☐	☐	☐	☐
Cancer, other	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐	☐
Genetic disease	☐	☐	☐	☐	☐	☐	☐

OTHER PERTINENT FAMILY HISTORY: ____

Alcohol Use	☐ Never used	☐ I quit using alcohol	☐ Social drinker	☐ Less than 2 days/week	☐ Daily
Tobacco Use	☐ I have never used tobacco products	☐ I quit using tobacco products	☐ I use tobacco products	☐**I would like to quit smoking**	
Illicit Drug Use	☐ I have never used illicit drugs	☐ I quit using illicit drugs	☐ I use illicit drugs	☐ I have used IV/ injection drugs	☐ I have or have had a drug problem
Education	Are you a student? ☐ Middle school ☐ High School ☐ College	☐ High school graduate	☐ GED	☐ College graduate	☐Master's degree or higher
Occupation	☐ Employed, full time	☐Employed, part time	☐ Unemployed	☐ Disabled	☐ Retired

REVIEW OF SYSTEMS Please check any of the SYMPTOMS below that you are currently experiencing or have experienced**.**

Y/N	Y/N	Y/N	Y/N	Y/N
☐☐ Fever	☐☐ Weight loss			
☐☐ Vision problems	☐☐ Blurred vision	☐☐ Hearing problems	☐☐ Nose bleeds	☐☐ Ringing in ears
☐☐ Rashes	☐☐ Changes in skin moles	☐☐ Unusual hair growth or hair loss		
☐☐ Breast lumps	☐☐ Breast pain	☐☐ Discharge from nipples		
☐☐ Chest pain	☐☐ Palpitations/ irregular heart rate	☐☐ Ankle swelling	☐☐ Heart murmur as an adult	☐☐ Coughing up blood
☐☐ Shortness of breath		☐ Chronic cough		
☐☐ Abdominal pain- upper	☐☐ Abdominal pain - lower	☐☐ Bloody or black tarry stool	☐☐ Diarrhea	☐☐ Constipation
☐☐ Nausea/Vomiting	☐☐Bloating	☐☐ Flatulence/gas	☐☐Changes in Appetite	☐☐ Heartburn
☐☐ Urinary frequency	☐☐ Urinary urgency	☐☐ Painful urination	☐☐ Bloody urine	☐☐ Urine leakage
☐☐ Difficulty starting urination		☐☐ Getting up frequently at night to urinate		
☐☐ Muscle aches	☐☐ Joint aches	☐☐ Back pain	☐☐ Stiffness	
☐☐ Headaches	☐☐ Seizures	☐☐ Blackouts or fainting spells	☐☐ Memory disturbance	☐☐ Numbness in extremities
☐☐ Cold intolerance	☐☐ Heat Intolerance	☐☐ Excessive thirst	☐☐ Hair /loss	☐☐ Hot flashes
	☐☐Night sweats		☐☐ Excessive sweating	
☐☐ Anxiety/ panic	☐☐ Depression	☐☐ Inability to concentrate	☐☐ Suicidal thoughts	
☐☐ Easy bruising	☐☐ Prolonged bleeding	☐☐ Swollen glands		

Patient Signature: ______________________ **Date:** ______________________

Provider Signature: ______________________ **Date:** ______________________

TABLE ROCK FAMILY MEDICINE
PATIENT INFORMATION

www.tablerockfamilymedicine.com

Thank you for choosing our office! In order to serve you properly, we need the following information. PLEASE PRINT. All information will be confidential.

Date ________________ Patient Name ________________________________ Home Phone ________________

FIRST MI LAST

SSN ______________________ ❑ Male ❑ Female Birthdate _______________ Cell Phone ________________

Address ____________________________________ City __________________ State ________ Zip __________

Check appropriate box: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Patient's or parent's employer ____________________________________ Work phone ______________________

Business Address _______________________________ City _______________ State _________ Zip _________

Spouse or parent's name __________________________ Employer _______________ Work phone ____________

Person to contact in case of emergency _____________________________________ Phone __________________

Responsible Party/ Insurance Information - Please present insurance cards

Name of person responsible for this account ____________________________ Relationship to patient ____________

Address ____ Home phone ___________________

Insurance Policy Holder's Name _____________________________________ ID# ______________________

Policy Holder's Birthdate ____ SSN ______________________

Secondary Insurance Policy Holder's Name ____________________________ ID# ______________________

Policy Holder's Birthdate ____ SSN ______________________

Employer ____ Work phone ___________________

Is this person currently a patient at our office? ❑ Yes ❑ No

Other Family Members Seen In This Office	DATE OF BIRTH	RELATIONSHIP
Name		
Name		

I am the legal guardian for ___________________________ and I hereby authorize the person(s) named below to sign for medical treatment of my child when I am not here.

Name: ______________________________________ Name: ______________________________________

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 to ask questions about our privacy practices.

I give permission for Table Rock Family Medicine to discuss my test results and/or medical information with:

Name: ______________________________________ Name: ______________________________________

Name: ______________________________________ Name: ______________________________________

I have had the opportunity to read and or receive a copy of the Notice Of Privacy Practices.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

______________________________________ ______________________________________

Signature of patient or parent if minor Date

301 LINVILLE ST, PO BOX 837, GLEN ALPINE, NC 28628
828-584-2481

CONTRACT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled substance medications (i.e. narcotics, tranquilizers, and barbiturates) are very useful but have a high potential for misuse and are closely controlled by the local, state, and federal governments. They are intended to relieve pain, improve function and ability to work, not simply to feel good.

Because my physician is prescribing or may in the future prescribe such medications for me to help manage my condition, I agree to the following conditions:

1. I will designate one pharmacy for all controlled substance prescriptions: ________________________________

2. I am responsible for my controlled substance medications. If the prescription or medication is misplaced or stolen or if I use it up sooner than prescribed, I understand that it will not be replaced.

3. I will not request or accept controlled substance medicine from any other physician or individual while I am receiving such medicine from Table Rock Family Medicine.

4. Refills of controlled substance medication will be made only during regular office hours. Refills will not be made at night, on holidays or weekends or if I cancel my appointment.

5. When requested, I will bring in the containers of all controlled medications prescribed by Table Rock Family Medicine even if there is no medication remaining. These will be in the original containers from the pharmacy for each medication, with the most current date.

6. I understand that if I violate any of the above conditions, my controlled substances prescription and/or treatment with Table Rock Family Medicine may be terminated. If the violation involves obtaining controlled substances from another physician, as described above, I may also be reported to my physician, medical facilities, and other authorities.

7. I agree to random periodic drug screening if the prescribing provider deems necessary.

I have been fully informed by Table Rock Family Medicine and the staff regarding psychological dependence (addiction) of a controlled substance, which I understand is rare. I know that some persons my develop a tolerance, which is the need to increase the dose of the medication to achieve the aim effect of pain control, and I do know that I will become physically dependent on the medication. This will occur if I am on the medication for several weeks. When I stop the medication I must do so slowly and under medical supervision or I may have withdrawal symptoms.

I have read this contract and it has been explained to me by a Table Rock Family Medicine staff person. I fully understand the consequences of violating this contract.

______________________________________ ________________________
Patient Signature Date

______________________________________ ________________________
Witness Signature Date

We will use your health information for regular health operations.

For example: Members of our staff may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

Business Associates: There are some services provided in our practice through contacts with Business Associates. Examples include diagnostic services and certain laboratory tests. When these services are contracted, we may disclose your health information to our Business Associates so that it can perform the job we've asked it to do. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Our staff, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Funeral Directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may leave a message on your answering machine regarding your upcoming visit. We may also send a postcard through the mail notifying you of normal labs and x-rays.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing urveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional Institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority, or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

EFFECTIVE DATE: April 14, 2003

NOTICE OF PRIVACY PRACTICES

TABLE ROCK FAMILY MEDICINE
301 LINVILLE STREET
GLEN ALPINE, NC 28628
828-584-2481

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Table Rock Family Medicine is here to serve your health care needs. We appreciate the trust you have placed in us, and we are committed to using protected health information about you responsibly.

UNDERSTANDING YOUR HEALTH INFORMATION

Each time you visit Table Rock Family Medicine, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as:

- A basis for planning your care and treatment
- A means of communication among the many health professionals who contribute to your care
- A legal document describing the care you received
- A means by which you or a third-party payer can verify that services billed were actually provided
- A tool in educating health professionals
- A source of information for public health officials charged with improving the health of the nation
- A source of data for our practice planning and marketing
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

An understanding of what is in your record and how your health information is used will help you to (1) ensure its accuracy, (2) better understand who, what, when, where, and why others may access your health information, and (3) make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of Table Rock Family Medicine, the information belongs to you. As provided for in the HIPAA Privacy Regulation, 45 CFR Part 160, you have the right to:

- Request a restriction on certain uses and disclosures of your information
- Obtain a paper copy of this Notice of Privacy Practices upon request
- Inspect and copy your health record
- Request an amendment to your health record
- Obtain an accounting of disclosures of your health information
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

RESPONSIBILITIES OF TABLE ROCK FAMILY MEDICINE

Our practice is required to:

- Maintain the privacy of your health information
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post a copy in our office in a prominent location. We will provide you with a copy of the revised Notice upon your request.

We will not use or disclose your health information without your authorization, except as described in this notice.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions and would like additional information, you may contact the Privacy Officer of Table Rock Family Medicine at (828) 584-2481.

If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer of Table Rock Family Medicine or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH OPERATIONS

We will use your health information for treatment.

For example: information obtained by the physician or another member of our staff will be recorded in your record and used to determine the course of treatment that should work best for you. Your provider will document in your record any expectations he or she has for the members of our staff. Our staff will then record the actions they took and their observations. In that way, the provider will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. We have developed this payment policy regarding patient and insurance responsibility for services rendered. Please read it, ask us any questions, and sign below. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments and deductibles.** All co-payments and deductibles must be paid, in full, at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients is considered fraud. Please help us uphold the law by paying your co-payment at each visit. We accept cash, checks, Visa, and MasterCard. There is a $25.00 service charge for all returned checks.

3. **Non-covered services.** Please be aware that some, and perhaps all, of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. **Proof of insurance.** All patients must complete our patient information form before seeing a provider. We must obtain a copy of a current insurance card to provide proof of insurance and provide insurance numbers. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

5. **Claims submission.** We will submit **all** claims in a timely manner, regardless of participation with insurance company, and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless discussed with our collection department. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our providers will only be able to treat you on an emergency basis. Any additional charges, as permitted by law, will be the patient's responsibility. Currently a 30% service fee will be added to all unpaid balances sent to a collection agency.

8. **Missed appointments.** We will send a reminder when an appointment is missed requesting you call and reschedule. If appointments are missed repeatedly, you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our providers will only be able to treat you on an emergency basis.

9. **Disability/Insurance forms.** We charge $10.00/form completion. Payment is due before forms are returned to patient.

10. **Motor Vehicle Accidents.** When seeing a provider for a motor vehicle accident or related problem, payment is expected at time of service. We will provide any information needed to help you receive payment from the auto insurance.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.
I have read and understand the payment policy and agree to abide by its guidelines.

____________________________________ ______________________

Signature of patient or responsible party Date