PATIENT MEDICAL HISTORY
Meridian Internal Medicine, P.A.

Home Phone: _____ Name: _____
Work Phone: _____ DOB: _____ Age:_____
Cell Phone: _____ Today's Date:_____
Email Address: _____
Emergency Contact: Name & Phone #_____

Please fill out the following information so that we may have an understanding of your current medical status.

What is the main reason you made this appointment? _____

Current medications (name of the drug and the dosage)

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Do you take any:
☐ Herbal Products
☐ Vitamins
☐ Minerals

Do you need refills on any of these medicines today? ☐ Yes ☐No

Drug Allergies Please check or list all drugs and the type of reaction.

☐I am not allergic to any medications
☐Penicillin Reaction _____
☐Sulfa Reaction _____
☐Codeine Reaction _____
☐Other_____ Reaction _____
☐Other_____ Reaction _____

Medical Problems Have you had (or do you have now) any of the following medical problems?

☐High Blood Pressure	☐Breast Cancer	☐Asthma	☐Kidney Stones
☐Heart Disease	☐Colon Cancer	☐Emphysema	☐Urinary Tract Infection
☐Heart Attack	☐Other Cancer	☐Tuberculosis	☐Positive HIV or AIDS
☐Stroke	☐Abnormal PAP	☐Sickle Cell	☐Seizure Disorder
☐Diabetes	☐Thyroid Disease	☐Anemia	☐Received Blood Transfusion
☐Kidney Disease	☐Hepatitis or Jaundice	☐Arthritis	☐Other (Describe below)

_____
_____

Past surgeries Have you had any of the following operations? If so, what year?

☐Appendix ____ year	☐Gall Bladder ____ year	☐Thyroid ____ year	☐Hysterectomy____year
☐Hernia _____ year	☐Heart _____ year	☐Lung _____ year	☐Other _____year

_____
_____

Hospitalizations you have had (other than surgery above or childbirth)

Year	Reason	Year	Reason

Smoking, Alcohol and Substance Use History

Cigarettes: Do you smoke now?: ☐Yes ☐ No Have you smoked in the past?: ☐Yes ☐ No
If yes, How many years did you smoke?: _____ When did you quit?: _____
Do you use other tobacco products: ☐No ☐ Cigars ☐ Chewing Tobacco ☐ Snuff ☐ Other
How much alcohol do you drink: ☐ None ☐Rarely ☐ 1-7 drinks/week ☐8-14 drinks/week ☐14+/week
Any substance use/abuse (such as marijuana, prescription medication, cocaine, etc.) in the past or presently? ☐ Yes ☐No
If yes, substance(s) used _____.

Please continue to next page

Social History

Coffee/Tea: cups or glasses per day: _____ Occupation: _____

Marital Status: ☐ Single ☐Married (spouse's name/age: _____) ☐Divorced ☐Separated ☐Widowed

Children's names & ages:_____

Do you exercise regularly?: ☐Yes ☐No Have you signed your drivers license as an organ donor? ☐Yes ☐No

Do you wear seatbelts?: ☐ Always ☐Often ☐Occasionally ☐ Never

Do you have firearms in your home?: ☐ Yes ☐ No If yes, are they kept locked up? ☐Yes ☐ No

Please note: HIV, the virus that causes AIDS is spread by blood or sexual contact. If you have had multiple sexual partners or have used IV drugs presently or in the past, you should consider discussing HIV testing with your healthcare provider.

Family History (blood relatives only) Check if any relative had any of the following diseases.

	Father	Mother	Grandparent	Siblings	Your Child	Aunt/Uncle
Diabetes	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Leukemia/Lymphoma	☐	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐
Prostate Cancer	☐	☐	☐	☐	☐	☐
Other Cancer	☐	☐	☐	☐	☐	☐
Sickle Cell	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐

Health Maintenance Give the month and year of the last time you had any of the following:

Women:
Pap Smear (if over age 21): _____
Mammogram (if over age 40):_____

Men (if over age 50):
Prostate blood test: _____

All:
Colonoscopy (if over age 50): _____
Stool test for blood (if over age 40): _____

Immunizations Please enter information about immunizations you have had.

Tetanus _____ (year)
Influenza Immunization _____ (year)
Tuberculosis Skin Test _____ (year)

Pneumonia ☐Yes ☐No
Hepatitis A ☐Yes ☐No
TB test positive ☐Yes ☐No

Chicken Pox ☐ Yes ☐No
Hepatitis B ☐ Yes ☐No
Shingles ☐Yes ☐No
HPV ☐Yes ☐No

If you were born after 1957, have you received a second measles vaccination? ☐ Yes ☐ No

Other healthcare providers (chiropractors, homeopaths, etc.)

_____

Advanced Directives Do you have a living will or medical durable power of attorney?

☐I have a living will ☐I have signed a medical durable power of attorney

_____ _____
Patient Signature (Stating he/she has completed this document to the best of their ability) Date

_____ _____
MD Signature (Stating she has reviewed this form with the patient.) Date

PATIENT REGISTRATION
Meridian Internal Medicine, P.A.

PATIENT INFORMATION

Name _____
Last First Middle Maiden

Address _____
Street or Post Office Box City State Zip

Telephone Number _____ Cell Phone Number _____

Email Address_____ Work Number _____

Sex (circle one): Male Female Date of Birth _____

Race (circle one): White Black Asian Hispanic Other _____

Status (circle one): Minor Single Married Widowed Divorced

Employer _____

Address _____
Street or Post Office Box City State Zip

Person Responsible for Bills (Guarantor) - If other than patient

Name _____
Last First Middle Maiden

Address _____
Street or Post Office Box City State Zip

Telephone Number _____ Relationship to Patient _____

Date of Birth _____ Social Security Number _____

INSURANCE INFORMATION

Primary Insurance Company Name

Policy Holder Name _____ Date of Birth _____

Policy Number _____ Group Number _____

Policy Holder Employer _____

Policy Holder Social Security Number _____

Relationship of Patient to Policy Holder _____

Secondary Insurance Company Name

Policy Holder Name _____ Date of Birth _____

Policy Number _____ Group Number _____

Policy Holder Employer _____

Policy Holder Social Security Number _____

Relationship of Patient to Policy Holder _____

PATIENT REGISTRATION CONTINUED -
Authorization /Guarantee of Payment/Release/Consent/ Power of Attorney/Acknowledgement

Insurance Assignment and Medicare/Medicaid Certification:

I, the undersigned, hereby authorize payment of health insurance benefits that I am entitled to per my benefits contract with my insurer, which are otherwise payable to me. This authorization will include those major medical benefits payable to the physician who rendered care on my behalf.

As a Medicare/Medicaid patient (if applicable), I hereby authorize payment of all claims filed by the above referenced provider of healthcare services, which are otherwise payable to me. I hereby authorize the provider of healthcare services to release any health information that may from time to time by required by Medicare/Medicaid in order to make final determination of payment of claims submitted by the provider for all medically necessary services rendered to me. I certify that the information given by me in applying for payment under Titles XVII and XIX of the Social Security Act are correct.

As the signer below, I attest that Meridian Internal Medicine has been requested to maintain my signature on file for the purpose of filing claims permitted by this assignment.

Guarantee of Payment:

I, the undersigned, hereby acknowledge that I am the guarantor on this account and, as such, will be responsible for payment of covered charges that are either medically necessary, or not medically necessary: covered by my healthcare insurer, or not covered by my healthcare insurer, which are not covered by the above referenced assignment. Once my healthcare insurer makes a final claims determination as reflected on their Explanation of Benefits received by my healthcare provider, I understand payment of the remaining balance is immediately due. The guarantee of payment also applies to items listed in the financial policy regarding missed appointments, form completion, etc.

Authorization for Release of Medical Information:

Meridian Internal Medicine is hereby authorized to release any medical information required in processing of applications, financial coverage of services rendered to me by Meridian Internal Medicine, and is authorized to provide the same to any other healthcare provider in order to ensure continuity of care. This includes information regarding Mental Health, HIV, Alcohol and Drug Dependency, as well as all medications.

Consent for Medical Treatment

I, the undersigned am knowingly requesting general medical services from Meridian Internal Medicine and that I am requesting these services willingly and voluntarily, I execute the same as my free and voluntary act for the purpose of receiving the healthcare services from Meridian Internal Medicine. By my signature below, I warrant that I am eighteen (18) years of age or older, of sound mind, and not constrained nor under undue influence. I understand that my physician will be responsible for providing me with an explanation of current information regarding my diagnosis, treatment, and prognosis (as applicable) and will require my consent on any procedures performed on me. My physician will ensure that I am adequately informed and understand the reasons for and indication of the procedure. I understand that I have the right to refuse such care, except in an emergency.

NC Health Information Exchange:

Meridian Internal Medicine is a member of the NC Health Information Exchange (NC HIE) which is a way of sharing health information among participating doctor's offices, hospitals, labs, radiology centers, and other health care providers through secure, electronic means. The purpose is so that each of your participating caregivers can have the benefit of the most recent information available from your other participating caregivers when taking care of you. The goal is for you to receive coordinated care more efficiently.

We have provided NC HIE educational brochures and other information throughout the office. Your health information will be visible to your caregivers through NC HIE unless you opt-out using the written form which available upon request from our front desk staff or contact NC HIE @ 1-855-926-1042.

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Acknowledgement as Signer on the Account:

Upon my signature below, I attest that I have read and understand all the provision discussed herein. Any questions I have asked have been answered to my satisfaction and to the extent where I can place my signature on this document, conveying in doing an acknowledgment of my full understanding of my rights and obligations as a patient of Meridian Internal Medicine, P.A. Should the patient be a legal minor as defined in the State of North Carolina Statute, I hereby attest as the signer below, that I am the lawful guardian of the minor.

_____ _____

Signature of Patient/Guarantor on the Account Date

_____

Relationship if Other than Patient

_____

Reason Patient Cannot Sign

_____ _____

Witness (staff member accepting registration document) Date

Power of Attorney Regarding Healthcare Services Rendered to a Minor:

As the legal guardian of the patient who is under the age of eighteen (18) years of age and who does not possess statutory authority to make his/her decisions regarding healthcare services rendered, I authorize the following persons to make these decisions in my absence and convey in listing them the legal authority to make such decisions.

Power of Attorney, as described herein, is hereby granted to the following individuals:

_____ _____

Name Date

_____ _____

Name Date

Meridian Internal Medicine, PA Financial Policy

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions, please discuss them with our billing staff or office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment.

Insured Patients

- Copays, Co-insurance and Deductibles are **due at the time of service**. For your convenience, we accept cash, personal check (in-state only) and most major credit cards.
- We will bill participating insurance companies as a courtesy to you.
- In the event that your insurance carrier determines a service to be "non-covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

Other

- Non-Insured patients will be required to pay **75% of the total charge .** This amount reflect 100% of the total charge less the 25% self pay discount which will be applied at the time of payment. Non insured patients will be required to pay via **cash or credit card** at the time of service.
- Overdue Balance: A patient with an outstanding balance of 60 days (2-monthly statements) overdue must make arrangements for payment **prior** to scheduling appointments. Financial agreements can be arranged if the need arises, but if the terms are not met by the patient, the account will be deemed delinquent and **collection action will be taken**.
- Form Completion (including but not limited to disability forms): A **$10 or $25 fee** (depending on complexity of form) will be applied to assist in the completion of forms. In most cases, this charge is not billable to your insurance. Patients will be required to pay via **cash or credit card** at the time of forms pickup or prior to submission (i.e. fax, mail).
- Returned Checks: A **$25 fee** will apply to all checks returned to our office as "unpaid". Payment for future services may be required by **cash or credit card**.
- Cancelled/Missed Annual Wellness (Physical) Appointments: A **$25 fee will** apply for patients that miss scheduled Annual Wellness (Physical) appointments.
- Cancelled/Missed Appointments: A **$25 fee** may apply for patients that repeatedly miss appointments. This **fee** may apply to patients that no show, cancel or reschedule appointments with less than 24 hours notice on a regular basis. Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Excessive abuse of scheduled appointments may result in **discharg**e from the practice.
- Medical Records: A fee may be charged for providing copies of medical records.

I have read and fully understand the policies of this office regarding payments and insurance.
I agree to pay for services and tests not covered by my insurance plan. I understand that I am responsible for following my insurance plan's regulations, policies and procedures.

_____ _____

Signature: Patient or Guarantor Date

_____

Printed Name: Patient or Guarantor

Revised: 03-01-11, 10-30-12, 2-23-16

Meridian Internal Medicine, P.A.
Authorization for Release of Information to Pharmacies

Name of Patient_____ Date of Birth _____

I authorize Dr. Prochnau and staff of Meridian Internal Medicine, P.A. to communicate with my pharmacy/ pharmacies. For the purpose of:

- Calling, faxing or sending prescription medication
- Verifying all medications prescribed to me by Dr. Prochnau and/ or any other health care provider
- Discussion with pharmacist regarding potential drug interactions
- Prescription medication history

I understand this would also be authorizing Dr. Prochnau and staff of Meridian Internal Medicine P.A. to disclose my medical history and treatment plans with the pharmacy.

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.-

Meridian Internal Medicine, P.A. P.O. Box 4937 Asheboro, NC 27204

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I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification to the address above.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I understand that the records to be released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

_____ _____

Signature of Patient or Personal Representative Date

Local Pharmacy: Name_____ Phone _____

Mail Order Pharmacy: Name_____ Phone_____

Other Pharmacy: Name_____ Phone_____

Meridian Internal Medicine, P.A.

Authorization for Release of Information

I, _____ _____
Name of Patient **Date of Birth**

Authorize Meridian Internal Medicine, PA which includes Dr. Caroline Prochnau and staff to release my protected health information to the following people and/or entities named below. Any changes to this information, including but not limited to revocation must be done so in writing. I understand the information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. *(The information may include medical related to treatment of alcohol, psychiatric care, psychological assessments, substance abuse, and/or HIV/AIDS, if applicable.)* I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

☐ Leave Message on my answering machine or voice mail

_____Home Phone Number _____Cell Phone Number

☐ Report test results to spouse, family or other (please list name(s))

_____

_____

☐ Discuss charges or payments on my account with spouse, family or other (please list name(s))

_____

_____

☐ Discuss confidential medical record with spouse, family or other (please list name(s))

_____

_____

☐ Other (List any specific instructions regarding disclosure of your health information)

_____

_____

☐ **EMERGENCY CONTACT**

_____ _____ _____
Name of Emergency Contact **Relation to Patient** **Area Code + Phone Number**

****

_____ _____
Signature of Patient or Authorized Representative **Date**

_____
Printed Name of Patient or Authorized Representative

☐ ***Patient Refused to Sign or Patient Unable to Sign due to:*_____**

_____ _____
Signature of Witness **Date**

Meridian Internal Medicine, P.A.
306 North Cox Street
Asheboro, NC 27203
TEL: 336-633-3073 FAX: 336-633-3074

Acknowledgement of Receipt of Notice of Privacy Practices and Patient Bill of Rights and Responsibilities

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information and *Patient Bill of Rights and Responsibilities*. I understand that this practice has the right to change its *Notice of Privacy Practices* and *Patient Bill of Rights and Responsibilities* from time to time and that I may contact this practice at any time at the address above to obtain a current copy of the *Notice of Privacy Practices* and *Patient Bill of Rights and Responsibilities.* I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date Signed: _____ Patient Date of Birth: _____

For Office Use Only

I attempted to obtain patient's signature in acknowledgement of the *Notice of Privacy Practices* and *Patient Bill of Rights and Responsibilities Acknowledgement,* but was unable to obtain because:

☐ An emergency existed and a signature was not possible at the time.

☐ The individual refused to sign.

☐ A copy was mailed with a request for a signature by return mail.

☐ Unable to communicate with the patient for the following reason:

_____

☐ Other: _____

Staff member: _____

Signature:_____ Date: _____