HEALTH HISTORY QUESTIONNAIRE

Name:	**Gender Identity:** ☐ Male ☐ Female ☐ Other	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Email address:		
Home address:		
Home phone:	**Mobile phone:**	
Work phone:		
Emergency contact:	**Emergency contact phone:**	
How is emergency contact related to you:		
Previous primary care doctor:	**Date of last physical exam:**	
Specialist you see:	**Date of last lab work:**	

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio				
Medical problems:	☐ High blood pressure		☐ Heart disease	Type:
	☐ High cholesterol		☐ Cancer	Type:
	☐ Seizures		☐ Lung disease	Type:
	☐ Diabetes	Type:	☐ Autoimmune disease	Type:
	☐ Stroke	Type:	☐ Infectious disease	Type:
	☐ Thyroid disease	Type:	☐ Kidney disease	Type:

List any other medical problems that other doctors have diagnosed

Surgeries

Year	Type of surgery	Reason

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes Year:	☐ No

List your prescribed medications		
Name of the Drug	Strength/Dose	How often is the medicine taken

Allergies to medications	
Name of the Drug	Reaction you had to the medication

HEALTH HABITS AND PERSONAL SAFETY							
Exercise	☐ Sedentary (No exercise)						
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)						
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)						
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)						
Diet	Are you following a specific diet (for example vegan)?						
	Number of meals you eat in an average day?						
	Rank sugar intake	☐ High	☐ Medium	☐ Low			
	Rank salt intake	☐ High	☐ Medium	☐ Low			
	Rank fat intake	☐ High	☐ Medium	☐ Low			
Occupation	☐ Retired	☐ Disabled	☐ Student	☐ Employed			
	Job title:						
Alcohol	How often do you have a drink containing alcohol?			☐ Never	☐ 2-4/month	☐ 4 or more/week	
				☐ Monthly or less	☐ 2-3/week		
	How many drinks containing alcohol do you drink in a day?			☐ 1 to 2	☐ 5 to 6	☐ 10 or more	
				☐ 3 to 4	☐ 7 to 9		
	How often do you drink more than 6 drinks or more on one occasion?			☐ Never	☐ Monthly	☐ Daily or most days	
				☐ Less than monthly	☐ Weekly		
Tobacco	Do you use tobacco?			☐ Yes		☐ No	
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day		☐ Cigars - #/day	
	☐ # of years	☐ Or year quit					
Drugs	Do you currently use recreational or street drugs?			☐ Yes		☐ No	
	Have you ever given yourself street drugs with a needle?			☐ Yes		☐ No	

Sexual History	Are you sexually active?	☐ Yes	☐ No
	If yes to above, are you sexually active with men, women, or both?		
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision loss?	☐ Yes	☐ No
	Do you have hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive such as a Living Will?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Siblings	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Over the last 2 weeks, how often have you been bothered by feeling little interest or pleasure in doing things?	☐ Not at all	☐ Several Days
	☐ More than half the days	☐ Nearly every day
Over the last 2 weeks, how often have you been bothered by feeling down, depressed or hopeless?	☐ Not at all	☐ Several Days
	☐ More than half the days	☐ Nearly every day

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Are you currently pregnant or breastfeeding?	☐ Yes	☐ No
Date of last pap?		
Date of last mammogram?		
Date of last bone density?		
Date of last colonoscopy?		

MEN ONLY

Date of last prostate/rectal exam?
Date of last PSA lab work?
Date of last colonoscopy?

Patient Signature:	**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 _____

Gender Identity (circle one): Male Female Other 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 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 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 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 healthcare provider 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.

North Carolina Health Information Exchange Authority:

Meridian Internal Medicine, PA is a member of the NC Health Information Exchange Authority (NC HIEA) 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.

The North Carolina state-operated health information exchange, called NC HealthConnex, is a secure electronic network that facilitates conversations between authorized health care providers by allowing them to access and share health-related information statewide. If you decide that you do not want your electronic health records to be shared by health care providers through NC HealthConnex, you have the right to opt out. You can assert your right to opt out by downloading the opt out form at http://hiea.nc.gov/patients and sending your completed form to the NC HIEA.

A copy of the NC HIEA Patient Information Brochures in the office's Patient Handbook.

Patient Handbook:

Meridian Internal Medicine, PA provides a patient handbook in each exam room as well as the lobby. Please reference this guide for office policies, procedures, educational material and more.

****

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.

_____ _____

Signature of Patient/Guarantor on the Account Date

_____

Relationship if Other than Patient

_____

Reason Patient Cannot Sign

_____ _____

Witness (staff member accepting registration document) Date

Revised: Patient Registration November 2015, September 2019

Meridian Internal Medicine, PA Financial Policy

In order to reduce confusion and misunderstanding, we have adopted the following financial policy. We regard your complete understanding of our financial policies as an essential element of your healthcare.

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/Letter Completion: A **fee** will be applied for forms and letters completed on patients behalf. The fee varies depending on complexity of form//letter. See current Menu of Prices for specific fees. (This Price Menu is posted throughout the office and available at the front desk.) 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 or Physical Appointments: A **$25 fee will** apply for patients that miss scheduled Annual Wellness or Physical appointments or who fail to provide at least **two business days** notice of cancellation.
- Cancelled/Missed Appointments: A **$10 fee will** apply for patients that miss a scheduled office visit or who fail to provide at least **two business days** notice of cancellation .
- Medical Records: A fee may be charged for providing copies of medical records.
- Other Provider Services (non face to face encounter): We will bill for non face to face provider encounters as permitted by regulatory agreements. These services may include but not limited to; patient portal services, patient phone calls, Home Health and Hospice care plan oversight, PT/INR home management, Advanced Care Planning, etc.

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. I also understand it is my responsibility to be familiar with my insurance plan and what services it covers.

_____ _____

Signature: Patient or Guarantor Printed Name: Patient or Guarantor

_____

Date

Revised: 03/01/11, 10/30/12, 2/23/16, 11/1/16, 9/1/19

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

Name of Patient_____ Date of Birth _____

I authorize my healthcare provider 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 my healthcare provider and/ or any other health care provider
- Discussion with pharmacist regarding potential drug interactions
- Prescription medication history

I understand this would also be authorizing my healthcare provider 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

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, Sharon Heyn, FNP-C 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: _____