Pinehurst Medical Clinic

Location: Pinehurst Medical Clinic Rheumatology – West End
4204 Murdocksville Road
West End, NC 27376

Dear New Patient of Pinehurst Medical Clinic Rheumatology – West End,

We are pleased to welcome you as a new patient of Pinehurst Medical Clinic Rheumatology – West End. To ensure the best possible experience during your upcoming visit, please take note of the following:

1. Plan on arriving at least 15 minutes prior to the scheduled time of your appointment to avoid delays.
2. Bring your medical insurance card(s) and medications with you on the day of your appointment.
3. Complete your new patient paperwork before coming to your appointment. If you need a paper copy mailed to you, please call (910) 695-2161 to make this request. Please allow at least 2 business days for your request to be processed, and an additional 5-7 business days to receive a paper copy in the mail.
4. If previous medical records are needed our office may contact you to make arrangements to obtain records.
5. Once you've established care, for urgent needs after hours, please call the office and follow the instructions to reach the provider on call.

We look forward to seeing you soon. In the event you need to cancel your appointment, we ask that you give us at least 24 hours' notice.

Sincerely,
PMC Rheumatology
(910) 255-0055

Pinehurst Medical Clinic

REGISTRATION FORM

PATIENT INFORMATION

Patient's Name:		
Address:		
City:	**State:**	**Zip Code:**
Home Phone:		
Mobile Phone:	**Other Phone:**	
Patient e-mail:		
Date of Birth:	**Sex:** □ Male □ Female	
Marital Status: □ Married □ Single □ Divorced □ Widowed □ Unknown		
Race: □ Black/African American □ Asian □ White □ American Indian/Alaskan Native □ Native Hawaiian/Other Pacific Islander □ Unknown		
Ethnicity: □ Hispanic □ Non-Hispanic		
Primary Language: □ English □ Spanish □ Other: _____		
Social Security Number:		
Primary Care Doctor:		

EMPLOYER INFORMATION

Employment Status: □ Employed □ Self-employed □ Retired □ Disabled □ Student □ Unemployed
Employer Name:
Employer Telephone:

EMERGENCY CONTACT

Emergency Contact Name:
Relationship to Patient:
Emergency Contact Phone:

RESPONSIBLE PARTY INFORMATION

Parent/Guardian Name:		
Address:		
City:	**State:**	**Zip Code:**
Telephone:		

INSURANCE INFORMATION

Insurance Company:	
Policy / Group Number:	**Effective Date – From:**
Subscriber Name:	**Patient's Relationship to Insured:**
Subscriber SSN:	**Subscriber's DOB:**
Subscriber Employer:	**Subscriber's Sex:** □ Male □ Female

Pinehurst Medical Clinic
RHEUMATOLOGY

Pinehurst Medical Clinic Rheumatology New Patient Health Questionnaire

To make your first visit more personal and comprehensive, please assist the provider in gathering the necessary information to aid in your health treatment plan. Filling this out thoughtfully ahead of time will limit delays in the waiting room.

Name: _____ Date: _____

Age: _____ Date of Birth: _____

Is your health good in general? ☐Yes ☐No

What are your current major medical problems?

_____

_____

_____

Are you being treated by another healthcare provider currently? If yes, please list below:

_____

_____

What medical conditions have you been treated for at any time?

Condition	Date of Onset	Condition	Date of Onset
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

What surgeries have you had?

Surgery	Approximate Date
1.	
2.	
3.	
4.	
5.	

Office use only – MRN#_____

What prescriptions are you taking? (Please bring bottles to your appointment)

_____
_____
_____

What over-the-counter medicines, vitamins, & other products do you use for your health?

_____
_____

List any allergic reactions you have had to medicine:

_____
_____

Family History

Relative	**Living? (Y/N)**	**Health Problems**
Mother		
Father		
Siblings		
Children		
Other		

Do you have a family history of: (Check any that apply)

☐ Arthritis ☐ Osteoporosis ☐ Lupus ☐ Autoimmune Disorder

Social History

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Do you have any children?

_____
_____

What type of work do you (or did you) do?

_____
_____

List any particular hobbies:

_____
_____

Have you ever smoked?

If yes: How many packs per day? _____ How many years? _____

Do you smoke pipes or cigars? ☐Yes ☐No

Have you ever quit smoking or tried to quit? If yes, when?

_____
_____

Do you use alcohol at present?

If yes: How many drinks per week? _____ What type of alcohol? _____

What time of day? _____

If no: Have you ever drank? _____

Do you exercise regularly? ☐Yes ☐ No

Describe:

_____
_____
_____

Do you use intravenous or street drugs? ☐Yes ☐No

Do you handle blood or blood products? ☐Yes ☐No

What type of diet do you maintain?

_____
_____
_____

Pinehurst Medical Clinic

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I authorize Pinehurst Medical Clinic to disclose the following information from the medical records of:

Patient Name: _____Date of Birth: _____

Address: _____

Telephone: _____Patient Number: _____

Covering the period(s) of health care:
From _____ to _____

From _____ to _____

Information to be disclosed:

☐ Complete health record(s), including all images (x-rays, photographs, etc.)
☐ Complete health record(s), excluding all images
OR
Select from the following (check as many as apply):

☐ Discharge Summary
☐ History and Physical Examination
☐ Consultation Reports
☐ Progress Notes
☐ Laboratory Tests
☐ X-ray reports
☐ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection
☐ Mental health care or services
☐ Psychotherapy Notes
☐ Treatment for alcohol and/or drug abuse
☐ Photographs, videotapes, digital or other images

☐ Other (please specify)
_____
_____

This information is to be disclosed to the following individual or entity for the purpose of:
_____
_____

Name:_____ Relationship: _____

Address:_____

Telephone: _____
The patient or the patient's representative must read and initial the following statements:

a. I understand that unless earlier revoked, this authorization will expire on ___/___/___ or on the happening of _____.
   Initials: _____

b. I understand that I may revoke this authorization at any time by notifying Pinehurst Medical Clinic in writing, but if I do it won't have any effect on any actions Pinehurst Medical Clinic took before it received the revocation.
   Initials: _____

c. I understand that Pinehurst Medical Clinic cannot make me sign this authorization as a condition to receive treatment from Pinehurst Medical Clinic except:

   (i) when Pinehurst Medical Clinic provides me with research-related treatment; or

   (ii) when Pinehurst Medical Clinic provides me with health care solely for the purpose of creating protected health information for disclosure to someone else.
   Initials: _____

Pinehurst Medical Clinic, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

(*Form MUST be completed before signing*)

_____
Signature of Patient or Representative

_____
Date

_____
Print Name

_____
Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of the Patient:

_____

_____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Pinehurst Medical Clinic

Pinehurst Medical Clinic Patient Payment Policy

1. Payment is due at the time of service. This may include deductibles, co-payments, co-insurance, and services not covered by an insurance company.
2. Payments may be made by cash, check, money order, MasterCard, Visa, Discover, or American Express.
3. You may receive a separate bill for services provided by a FirstHealth Cardiology & Specialty Clinic provider at PMC.
4. Patients without insurance may be eligible to receive a discount for payment in full on the day services are provided. You will need to speak to a Patient Account Representative.
5. A No-Show Charge will apply should you fail to keep your scheduled appointment without giving us a 24-hour or greater advanced notice of your cancellation. Three (3) consecutive appointment cancellations and/or no-shows may result in dismissal from Pinehurst Medical Clinic. The No-Show fees are $75 for a new patient office visit, $25 for an established patient office visit, and $25-$250 for procedure/testing appointments.
6. Patients may be charged a fee for the completion of forms.
7. Patients who feel their level of income is not sufficient to enable them to pay the amount they owe may apply for financial assistance by completing an application. This application may be obtained from one of our financial representatives or by calling Financial Services at 910-295-9392. Please note in general, financial assistance is extended only to patients whose family income is at or below 150% of the federal poverty limits.
8. Balances due after your insurance has paid will be reflected on billing statements sent to the patient's, or responsible party's, address. The amount due on the statement is due in full upon receipt. If you are unable to pay the amount in full it is your responsibility to call Financial Services to discuss making other payment arrangements.
9. Unpaid charges billed to your insurance will appear on your statement indicating they are pending a response from the insurance company. If a charge has been filed with your insurance for over 60 days without a response, please contact your insurance company. If the charge remains unpaid it may become your financial responsibility.
10. It is important to remember that health insurance coverage and plans vary, and not all charges will be covered or paid in full. If your insurance denies a service or does not pay in full, you are responsible for paying the remaining balance.
11. Services received as a result of an accident are to be paid promptly. We do not allow additional time for payment where the accident results in a lawsuit or insurance case.
12. If your health insurance plan requires a preauthorization or referral, it is your responsibility to ensure it is obtained before services are received.
13. New patient visits are coded per industry standards based on whether the patient is new to the specialty or subspecialty. Reference the following link for additional information: https://www.aapc.com/blog/41276-new-vs-established-patients-whos-new-to-you/
14. Failure to pay a balance due promptly may result in one or more of the following:
    a. Your account may be referred to a collection agency,
    b. Your past due status may be reported to the applicable credit bureaus,
    c. Your ability to receive services from Pinehurst Medical Clinic may be jeopardized.

We encourage those who have questions regarding this policy document or any aspect of their bill to contact us at (910) 295-9391 or toll-free at (866) 327.3159.

Pinehurst Medical Clinic

Access Your Health Information Online

Where you need it, when you need it.

Powered By FollowMyHealth

An all-in-one personal health record & patient portal that lets you access your health information online & on the go!

- View test & lab results
- Receive email care reminders
- Send & receive secure online messages
- Request appointments
- Request Rx refills
- Set up proxy accounts for children & dependent adults

To get started with a new account, give receptionist your email. To log in to an existing account, scan below.

Questions?

Call (910) 235-3380 or email fmhsupport@pinehurstmedical.com