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. To find a list of PMC's contracted payers or to review additional insurance information, please visit pinehurstmedical.com/resources-category/insurance
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

Pinehurst Medical Clinic Consent for Release of Protected Health Information to Family

I consent to disclosure of the following protected health information about me to the following family member(s) or person(s) involved in my care or payment of my care:

1. _____ Phone: _____ Relationship: _____

2. _____ Phone: _____ Relationship: _____

3. _____ Phone: _____ Relationship: _____

Check all that apply:

- ☐ All of my medical information
- ☐ Information necessary to schedule appointments for me
- ☐ Lab or test results
- ☐ Information necessary to provide, call in or pick up prescriptions for me
- ☐ Information necessary to help my family member(s) to pick up or arrange for medical equipment to be provided to me
- ☐ Information necessary to bill for or submit claims for care provided to me to government or private insurance payers

My consent will remain in effect as long as I am a patient at Pinehurst Medical Clinic, unless and until I notify Pinehurst Medical Clinic in writing of any changes.

Patient Name (printed): _____

Patient/Legal Guardian Signature: _____ Date: _____

Relationship to patient: _____

Pinehurst Medical Clinic

Account #_____

Patient Acknowledgment and Authorization

Please initial each section and sign to indicate acknowledgment and authorization.

_____ **Patient Payment Policy**
I have read and understand the Pinehurst Medical Clinic, Inc. Patient Payment Policy and I agree to pay for treatment rendered to me/the patient.

_____ **Notice of Privacy Practices**
I understand that Pinehurst Medical Clinic, Inc. will use and disclose my/the patient's health information for the purposes of treatment, payment, and healthcare operations, as permitted by law. Further information can be found in the Notice of Privacy Practices, which has been offered to me.

_____ **Assignment of Insurance Benefits**
I authorize the payment of medical benefits to Pinehurst Medical Clinic, Inc., and hereby assign to Pinehurst Medical Clinic, Inc. and the professionals involved in my/the patients care, all rights and claims for reimbursement under any private health insurance policy, Medicare, Medicaid, or any other programs that I identify for which benefits may be available to pay for the services provided to me/the patient.

_____ **Consent to Treat**
I, the Patient/the Patient's Legal Representative, hereby grant permission to Pinehurst Medical Clinic, Inc., and its authorized representatives to perform examinations/treatment deemed necessary or advisable for diagnosis and treatment.

_____ **Patient Rights and Responsibilities**
I understand that I have the right, and the responsibility, to participate in my/the patient's care and treatment. I understand that I have the right to be informed about the treatment being recommended, and the responsibility to ask questions if I do not understand it. I agree to provide accurate and complete information about my/the patient's health history and presenting complaint, to agree upon a treatment plan, and follow that plan. I understand that the Pinehurst Medical Clinic health care providers will treat me with respect,
and I agree to do the same for them.

Patient Name (printed): _____

Patient/Legal Guardian Signature: _____ Date: _____

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