"The Power of Touch"

Karen L. Smith MD, PA
929 West Prospect Ave.
Raeford, NC 28373

Patient Registration Information

Dear Karen L. Smith MD, PA patient:

Welcome to Karen L. Smith MD, PA. Thank you for allowing us the opportunity to assist with your healthcare needs. We value all of our patients and are committed to providing you with high-quality, health care services.

This packet includes all of the new patient forms that will need to be completed in order for us to assist with your care.

1. Financial Policy
2. Insurance Signature File
3. Information Release
4. Patient Health History
5. Record Release

Please take time prior to your appointment to review and complete the registration forms to the best of you knowledge. We ask that you bring the completed forms to your appointment along with your insurance card.

Please arrive 15 minutes early to your appointment. If you need assistance in locating the practice directions can be found on our website www.karensmithmd.com

Here at the office of Karen L. Smith MD, PA the staff is looking forward to assisting you with your health needs. If you have any questions, please call the practice at (910)-904-1695 Monday- Friday 8AM-5PM and one of our team members will be happy to assist you. If, it is an emergency after hours please feel free to contact us at 888-562-0298.

Sincerely,

Karen L. Smith MD, PA & Staff

Medicare Shared Savings Program
Accountable Care Organizations

I am _____ participating in Aledade Laffey ACO, LLC, an Accountable Care Organization (ACO). An ACO is a group of doctors, hospitals, and/or other health care providers that work together to improve the quality and experience of care you receive. ACOs receive a portion of any savings that result from reducing costs and meeting quality requirements.

- Medicare evaluates how well each ACO meets these goals every year. Those ACOs that do a good job can earn a financial bonus. ACOs that earn a bonus may use the payment to invest more in your care or share a portion directly with your providers. ACOs may owe a penalty if their care increases costs.
- My _____ participation in Aledade Laffey ACO, LLC doesn't limit your choice of health care providers. Your Medicare benefits are not changing. You still have the right to visit any doctor, hospital, or other provider that accepts Medicare at any time, just like you do now.
- To help us coordinate your health care better, Medicare shares information about your care with your providers. If you don't want Medicare to share your health care information, call 1-800-MEDICARE (1-800-633-4227).

How do ACOs work?

- An ACO **isn't** a Medicare Advantage plan which is an "all in one" alternative to Original Medicare, offered by private companies approved by Medicare. An ACO **isn't** an HMO plan, or an insurance plan of any kind.

Important!

- ACOs have agreements with Medicare to be financially accountable for the quality, cost, and experience of care you receive.
- Coordinated care can avoid wasted time and costs for repeated tests and unneeded appointments. It may make it easier to spot potential problems before they become more serious – like drug interactions that can happen if one doctor isn't aware of what another has prescribed.
- ACOs may use electronic health records, case managers, and electronic prescriptions to help you stay healthy. Some ACOs have special programs to encourage you to have a primary care visit or use their care management team. Participation in these programs is optional.

What information will be shared about me?

- Medicare shares information about your care with your health care providers; like dates and times you visited a health care provider, your medical conditions, and a list of past and current prescriptions. This information helps Aledade Laffey ACO, LLC track the care and tests that you've already had.
- Sharing your data helps make sure all the providers involved in your care have access to your health information when and where they need it.
- **We value your privacy**. ACOs must put important safeguards in place to make sure all your health care information is safe. We respect your choice on how your health care information is used for care coordination and quality improvement. If you want Medicare to share your health care information with Aledade Laffey ACO, LLC or other ACOs in which your health care providers participate, there's nothing more you need to do.

- If you **don't** want Medicare to share your health care information, **call 1-800-MEDICARE** (1-800-633-4227). Tell the representative that your health care provider is part of an ACO and you don't want Medicare to share your health care information. TTY users should call 1-877-486-2048.
- If you change your mind and want to let Medicare share your health information again, call 1-800-MEDICARE to let Medicare know. We aren't allowed to tell Medicare for you.
- Even if you decline to share your health care information, Medicare will still use your information for some purposes, like assessing the financial and quality of care performance of the health care providers participating in ACOs. Also, Medicare may share some of your health care information with ACOs when measuring the quality of care given by health care providers participating in those ACOs.

How can I make the most of getting care from an ACO?

- Ask your clinician if they have a secure online portal that gives you 24-hour access to your personal health information, including lab results and provider recommendations. This will help you make informed decisions about your health care, track your treatment, and monitor your health outcomes.
- As a Medicare beneficiary, you can choose or change your primary clinician or "main doctor" at any time. Your primary clinician is the health care provider that you believe is responsible for coordinating your overall care. If you choose a primary clinician, that clinician may have more tools or services to help with your care. You can learn more in the Voluntary Alignment Beneficiary Fact Sheet.

For step-by-step instructions on how to select or change your "main doctor," refer to the Choosing a Primary Clinician video (https://youtu.be/JHPxtKftSTA).

What if I have concerns about being part of an ACO?

- If you have concerns about the quality of care or other services you receive from your ACO or provider, you can contact your Medicare Beneficiary Ombudsman who can assist you with Medicare-related questions, concerns, and challenges. The Medicare Beneficiary Ombudsman works closely with the Medicare program, including Medicare.gov, 1-800-MEDICARE, and State Health Insurance Assistance Programs (SHIPs), to help make sure information and assistance are available for you. Visit Medicare.gov for information on how the Medicare Beneficiary Ombudsman can help you.
- If you suspect Medicare fraud or abuse from your ACO or any Medicare provider, we encourage you to make a report by contacting the HHS Office of Inspector General (1-800-HHS-TIPS) or your local Senior Medicare Patrol (SMP).

Programa de Ahorros Compartidos de Medicare
Organizaciones Responsables de la Salud

I am _____ participando en Aledade Laffey ACO, LLC, una Organización Responsable por el Cuidado de la Salud (ACO). Una ACO es un grupo de médicos, hospitales y/u otros proveedores de la salud que trabajan juntos para mejorar la calidad y la experiencia del cuidado que recibe. Las ACO reciben una parte de los ahorros que resultan de la reducción de costos y cumplimientos con los requisitos de calidad.

- Medicare evalúa qué tan bien cada ACO cumple con estos objetivos cada año. Las ACO que hacen un buen trabajo pueden ganar un bono financiero. Las ACO que obtienen un bono pueden usar el pago para invertir más en su cuidado o compartir una parte directamente con sus proveedores. Las ACO pueden deber una multa si su cuidado aumenta los costos.
- My _____ participación en Aledade Laffey ACO, LLC no limita su elección de proveedores de la salud. Sus beneficios de Medicare no están cambiando. Todavía tiene derecho a visitar a cualquier médico, hospital u otro proveedor que acepte Medicare en cualquier momento, tal como lo hace ahora.
- Para ayudarnos a coordinar mejor su cuidado médico, Medicare comparte información sobre su cuidado de la salud con sus proveedores. Si no desea que Medicare comparta su información médica, llame al 1-800-MEDICARE (1-800-633-4227).

¿Cómo funcionan las ACOs?

- Una ACO **no es** un plan Medicare Advantage que es una alternativa "todo en uno" al Medicare Original, ofrecida por compañías privadas aprobadas por Medicare. Una ACO **no es** un plan HMO, o un plan de seguro de ningún tipo.

¡Importante!

- Las ACOs tienen acuerdos con Medicare para ser financieramente responsables de la calidad, el costo y la experiencia del cuidado que recibe.
- El cuidado coordinado puede evitar el desperdicio de tiempo y costos por pruebas repetidas y citas innecesarias. Puede hacer que sea más fácil detectar problemas potenciales antes de que se vuelvan más serios, como las interacciones farmacológicas que pueden ocurrir si un médico no está al tanto de lo que otro ha recetado.
- Las ACOs pueden usar registros médicos electrónicos, administradores de casos y recetas electrónicas para ayudarlo a mantenerse saludable. Algunas ACOs tienen programas especiales para alentarlo a que tenga una visita de cuidado primario o use su equipo de administración del cuidado. La participación en estos programas es opcional.

¿Qué información se compartirá sobre mí?

- Medicare comparte información sobre su cuidado con sus proveedores la salud; como fechas y horas en que visitó a un proveedor del cuidado de la salud, sus afecciones médicas y una lista de recetas pasadas y actuales. Esta información ayuda a Aledade Laffey ACO, LLC administrar el cuidado y las pruebas que ya le hicieron.
- Compartir sus datos ayuda a asegurarse de que todos los proveedores involucrados en su cuidado tengan acceso a su información de salud cuando y donde la necesiten.

- **Valoramos su privacidad.** Las ACOs deben establecer salvaguardas importantes para garantizar que toda su información médica esté segura. Respetamos su elección sobre cómo se utiliza su información médica para la coordinación del cuidado de salud y la mejora de la calidad. Si desea que Medicare comparta su información médica con Aledade Laffey ACO, LLC u otras ACOs en las que participan sus proveedores de la salud, no hay nada más que hacer.
- Si **no desea** que Medicare comparta su información médica, **llame al 1-800-MEDICARE** (1-800-633-4227). Dígale al representante que su proveedor de la salud es parte de una ACO y que no desea que Medicare comparta su información. Los usuarios de TTY pueden llamar al 1-877-486-2048.
- Si cambia de opinión y desea que Medicare comparta nuevamente su información de salud, llame al 1-800-MEDICARE para informarle a Medicare. No podemos informarle a Medicare por usted.
- Incluso si se niega a compartir su información médica, Medicare seguirá utilizando su información para algunos fines, como evaluar el desempeño financiero y de calidad del cuidado de los proveedores que participan en las ACOs. Además, Medicare puede compartir parte de su información médica con las ACOs al medir la calidad del cuidado brindada por los proveedores que participan en esas ACOs.

¿Cómo puedo aprovechar al máximo el cuidado de una ACO?

- Pregúntele a su médico si tiene un portal seguro en línea que le brinde acceso las 24 horas a su información médica, incluyendo los resultados de laboratorio y las recomendaciones de los proveedores. Esto lo ayudará a tomar decisiones informadas sobre su cuidado médico, hacer un seguimiento de su tratamiento y controlar sus resultados de salud.

Para instrucciones paso a paso. sobre cómo seleccionar o cambiar su "médico primario",consulte el video Elección de un Médico Primario (https://youtu.be/Oe-Gpw1pICU).

- Como beneficiario de Medicare, puede elegir o cambiar su médico de cabecera o "médico primario" en cualquier momento. Su médico primario es el proveedor que usted considera responsable de coordinar su cuidado general. Si elige un médico primario, ese médico puede tener más herramientas o servicios para ayudarlo con su cuidado. Puede obtener más información en la Hoja Informativa del Beneficiario de Alineación Voluntaria.

¿Qué sucede si tengo inquietudes acerca de ser parte de una ACO?

- Si tiene inquietudes sobre la calidad del cuidado u otros servicios que recibe de su ACO o proveedor, puede comunicarse con su Defensor del Beneficiario de Medicare que puede ayudarlo con preguntas, inquietudes y desafíos relacionados con Medicare. El Defensor del Beneficiario de Medicare trabaja en estrecha colaboración con el programa de Medicare, que incluye Medicare.gov, 1-800-MEDICARE y los Programas Estatales de Asistencia de Seguro Médico (SHIP), para ayudar a garantizar que la información y la ayuda estén disponibles para usted. Visite Medicare.gov para más información sobre cómo el Defensor del Beneficiario de Medicare puede ayudarle.
- Si sospecha de fraude o abuso de Medicare por parte de su ACO o de cualquier proveedor de Medicare, lo alentamos a que haga un informe comunicándose con la Oficina del Inspector General del HHS (1-800-HHS-TIPS) o su Patrulla Senior de Medicare local (SMP).

Financial Policy

Karen L. Smith MD, PA wants to provide our community with healthcare services while, keeping healthcare expenses manageable. We ask you to read our payment policy listed below:

- **Your bill is based on the services you received. You are responsible for paying your bill if your insurance company does not cover all the costs.**
- **What your health insurance covers is based on an agreement between you, the patient, and your insurance company.**
- **You need to contact your insurance company with any questions about what they will cover, prior to your appointment.**
- **We understand that temporary financial problems can sometimes prevent you from making a payment on your account on time. If this happens, you will be responsible for contacting our office, so that we may assist you with establishing a payment plan or enrollment in our sliding fee program.**

IF YOU <u>DO NOT</u> HAVE HEALTH INSURANCE (Self Pay)

<u>Your Responsibility</u>

- You must pay your entire bill at the time of service or inform us of your inability to pay, so that we may attempt to enroll you in our **Sliding Fee Program**.
- Self Pay Visit Pricing
  - New Patient Visit : **$260.00 for initial visit**
  - Established Patient Visit : **$175.00 per visit**

<u>Our Responsibility</u>

- We will **not** provide services if you are able to pay but chose not to pay.
- We are willing to talk to you about ways to pay, if you cannot pay the full amount.

IF YOU HAVE HEALTH INSURANCE

We participate with many insurance companies. This means we have signed a contract with them to provide care to their beneficiaries. The contracts are not all the same , and certain services may not be covered depending on your insurance policy.

If we DO participate with Your insurance plan:

<u>Your Responsibility</u>

- You must pay your co-payment at the time you receive the service.
- You must pay any deductible amount or any amount that you know is not covered at the time of service.
- You must pay the amount not paid by the insurance within **30** days of receiving your bill. You must pay any additional amount not covered by your insurance company. If you do not pay or create arrangements with our office within the **30** days of receiving your bill we will begin collection efforts.

<u>Our Responsibility</u>

- We will send a bill to your insurance company for all services done in our office.

If we DO NOT participate with Your insurance plan:

Your Responsibility

- You must pay for the services at the time it is given
  - To make it simple, our office accepts cash, checks, VISA, MasterCard, Discover.
  - We will charge a $25.00 fee for any returned checks.

Our Responsibility

- After you have paid us, we will send your bill to your insurance company. Your insurance will then pay you, if they chose to honor the amount we billed for.

NO SHOW POLICY

If you are unable to keep your appointment, kindly call the office at least (24 hours minimum) in advance to cancel or reschedule so that others may use the time we had reserved for you. If you do not call 24 hours prior to the day of your appointment a $25.00 no show fee will be charged to your account, and will be collected at your next visit.

STATEMENT OF FINANCIAL RESPONSIBILITY

_____The patient who receives care and treatment from Dr. Karen L. Smith MD, PA office must pay any charges that are not paid by insurance or any other party.

_____ Other providers, such as laboratory vendors, will bill the patient separately.

_____ The patient must pay any amount not paid by the insurance within **30** days of getting billed, If Karen L. Smith MD, PA needs to use a collection agency or attorney to collect the unpaid amount, the patient may also be held responsible for paying any fees accrued by the agency or attorney to Karen L. Smith MD, PA.

Karen L. Smith, MD, PA reserves the right to terminate the patient- physician relationship and/or dismiss the patient from the practice after an excessive amount of missed, appointments occur. Karen L. Smith, MD, PA will issue a warning to the patient prior to proceeding with dismissal from the practice.

Patient Signature: _____ **Date:** _____

INSURANCE SIGNATURE ON FILE

PATIENT'S NAME: ______________________________ DOB: _________________

I request that payment of authorized commercial Benefits, Medicare or Secondary Medicare coverage benefits be made directly to the office of Karen L. Smith MD, PA for any services furnished to me by the provider of service. I understand that I am financially responsible for charges not covered by the authorization. I authorize any holder of medical information to release to my insurance company or its agents any information, which may be necessary to determine benefits payable for related services.

______________________________	______________________________
Primary Identification Number	Secondary Identification Number
______________________________	______________________________
Primary Insurance	Secondary Insurance
____________________	____________________________________
Date	Signature of Patient (or Parent, if patient is a minor)

****

______________________________	______________________________
Primary Identification Number	Secondary Identification Number
______________________________	______________________________
Primary Insurance	Secondary Insurance
____________________	____________________________________
Date	Signature of Patient (or Parent, if patient is a minor)

****

______________________________	______________________________
Primary Identification Number	Secondary Identification Number
______________________________	______________________________
Primary Insurance	Secondary Insurance
____________________	____________________________________
Date	Signature of Patient (or Parent, if patient is a minor)

****

______________________________	______________________________
Primary Identification Number	Secondary Identification Number
______________________________	______________________________
Primary Insurance	Secondary Insurance
____________________	____________________________________
Date	Signature of Patient (or Parent, if patient is a minor)

****

Karen L. Smith, MD, PA
The Power of Touch

Karen L. Smith, MD, PA
Family Practice
929 West Prospect Avenue
Raeford, NC 28376
P: 910-904-1695 F: 910-904-1767 E: info@karensmithmd.com
www.karensmithmd.com

A. **Notifier (Employee's Name):**
B. **Patient Name:**
C. **Identification Number:**

Advance Beneficiary Notice of Non-Coverage (ABN)

NOTE: If your insurance _____ does not pay for D._____ (rendered services) below, you may have to pay out-of-pocket. Your insurance _____ may not cover certain services, even if the services have been determined to be medically necessary by your health care provider. We anticipate that your insurance _____ will not cover/pay for the rendered service, D._____, below.

D. Rendered Service	E. Reason Your Insurance May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

1. Read this notice, so you can make an informed decision about your care.
2. Ask us any questions that you may have after you finish reading.
3. Choose an option below about whether to receive the D. _____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

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G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the D. _____ listed above. You may ask to be paid now, but I also want _____ billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if _____ does not pay, I am responsible for payment, but I can appeal to _____ by following the directions on the MSN. If _____ does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the D. _____ listed above, but do not bill _____. You may ask to be paid now as I am responsible for payment. I cannot appeal if _____ is not billed.

☐ **OPTION 3.** I do not want the D. _____ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if _____ would pay.

H. Additional Information:

This notice gives our opinion, not an official decision from your insurance company _____. If you have other questions on this notice or your insurance company's billing, please call your beneficiary service number listed on the back of your insurance card. Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	**J. Date:**

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Discount/ Sliding Fee Schedule Program
Karen L. Smith, MD, PA

The practice of Karen L. Smith, MD, PA is a family medical practice that provides comprehensive primary care, preventive care, community health, medication assisted treatment, and other health-related services to residents of its community, regardless of the individual's or the family's ability to pay.

The practice of Karen L. Smith, MD, PA will assist patients in determining if they are eligible to participate in our Discount/ Sliding Fee Program. Patient's must provide the following information and complete this application to be enrolled in the Discount/ Sliding Fee Program.

If eligible, this Discount/ Sliding Fee Program will only apply to services rendered at and by the practice of Karen L. Smith, MD, PA and Karen L. Smith, MD, FAAFP.

Patient will need to provide recent proof of income for all family members/ individuals living in the household. The following are acceptable forms of proof of income:

- Previous year 1040 tax form
- At least one month pay stub (must be most recent pay stub)
- 1 unemployment stub (must be most recent unemployment stub)
- Food Stamp award letter
- Copy of Social Security or Disability Check
- Letter from employer that states your salary or wages

Eligibility and discount amount for those patients that qualify will be determined using the 2022 Slide Fee Schedule and the 2022 Federal Poverty Guidelines.

I certify that, I, _____, have read the entirety of this form and acknowledge that I am seeking approval for the Discount/ Sliding Fee Program offered to patients of Karen L. Smith, MD, PA. I understand that my eligibility can only be determined by providing one of the above listed documents. I understand that my discount is already pre-determined based off my level status associated with my income and household size. I understand that I am expected to uphold integrity and provide unaltered, legitimate documentation. I understand that my eligibility will be re-evaluated annually to assess need for enrollment status. Upon request, I will provide additional documentation that attests to my most current income and household size.

If you agree to the above statement, please print, and sign your name below followed by the date of signing.

Print Name _____

Signature _____

Date _____

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Sliding Fee Discount Application
Financial & Household Information

Name _____

DOB _____/_____/_____

Street Address _____
City _____ State _____ Zip Code _____
Phone Number _____
Email _____

Please list all household members, including those under age 18.

	Name	**Date of Birth**
Self		
Other		
Other		
Other		
Other		
Other		
Other		

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Please complete financial information.

Source	Self	Other	Total	
Gross wages, salaries, tips, etc.				
Income from business and self-employment				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension, or retirement income				
Interest; dividends; royalties; income from rental properties, estates, and trusts; alimony; child support; assistance from outside the household; and other miscellaneous sources				
Total Income				

I certify that the family size and income information shown above is correct.

Name (Print) _____ Date _____
Signature _____ Date _____

Patient Information Release Form

I, _____ (Patient's Name) _____ (Patient's DOB) give permission to Karen L. Smith, MD, PA to fully disclose any medical-related information and/or information impacting my health status to the following individual(s):

Name:_____ Relationship: _____

Name:_____ Relationship: _____

Name:_____ Relationship: _____

Name:_____ Relationship: _____

I grant this/ these individual(s) the right to access my full medical records/ health information, financial information as it pertains to the practice, to be involved in all conversations regarding my health care decisions and health care needs that take place between myself, the providers, clinical team, and/or administrative team at Karen L. Smith, MD, PA.

I maintain my right to revoke the access granted to this/ these individual(s) by signing this form at any time. If I decide to revoke access from this/ these individual(s), it is my responsibility to contact the practice of Karen L. Smith, MD, PA and update this information appropriately.

The practice of Karen L. Smith, MD, PA will not be held liable if my health information is mishandled by this/ these individual(s) once access is granted by me, the patient, following the completion of this release form.

Patient Signature: _____ Date: _____

Patient Health History Questionnaire

Name: _____ **Sex: M/F** **DOB:** _____ **Today's Date:** _____

Race: _____ **Ethnicity:** _____

List All Prescriptions and over-the-counter medications, supplements and vitamins you take including the dose or strength

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Allergies: _____

Latex Allergy: Yes / No

PAST MEDICAL HISTORY

Do you have now or have you ever had any of the following?

Heart Disease	Yes	No	Hyperthyroid	Yes	No
Heart Attack	Yes	No	Kidney Stones	Yes	No
Heart Arrhythmia	Yes	No	Kidney Disease	Yes	No
Atrial Fibrillation	Yes	No	Stroke	Yes	No
Congestive Heart Failure	Yes	No	Gallbladder Disease	Yes	No
Hypertension	Yes	No	Anemia	Yes	No
Vascular Disease	Yes	No	Chronic Back Pain	Yes	No
Diabetes	Yes	No	Rheumatoid Arthritis	Yes	No
* Insulin Dependent	Yes	No	Lyme Disease	Yes	No
* Non-Insulin Dependent	Yes	No	Psoriasis	Yes	No
High Cholesterol	Yes	No	Depression	Yes	No
Lung Disease	Yes	No	Osteoporosis	Yes	No
Asthma	Yes	No	Neuropathy	Yes	No
Reflux Disease (GERD)	Yes	No	Hypothyroidism	Yes	No
Ulcers	Yes	No	Fibromyalgia	Yes	No
Cancer (location) _____	Yes	No	Colitis	Yes	No
Blood Clots (DVT or PE)	Yes	No			

Other: _____

PAST SURGICAL HISTORY

Please list any operations you have had:

_____
_____
_____
_____
_____
_____

FAMILY/SOCIAL HISTORY

Occupation: _____ Marital Status: Single Married Widowed Divorced

Your personal habits: Do you?			**Do you have a Family History of:**			**Relationship**
Exercise Regularly	Yes	No	Heart Disease	Yes	No	_____
Smoke or use Tobacco	Yes	No	High Blood Pressure	Yes	No	_____
* How much _____			Diabetes	Yes	No	_____
* For how many years _____			Stroke	Yes	No	_____
Used tobacco in the past	Yes	No	Cancer	Yes	No	_____
Drink Alcohol	Yes	No	Thyroid Disease	Yes	No	_____
* How much _____			Depression	Yes	No	_____
Recent Tick Bites	Yes	No	Blood Clots	Yes	No	_____

REVIEW OF SYSTEMS

Have you recently been troubled with any of the following symptoms:

Backache	Yes	No	Bloody Sputum	Yes	No
Leg Pain	Yes	No	Indigestion	Yes	No
Painful Joints	Yes	No	Abdominal Pain	Yes	No
Headaches	Yes	No	Diarrhea	Yes	No
Double Vision	Yes	No	Constipation	Yes	No
Difficulty Swallowing	Yes	No	Change in Bowel Habits	Yes	No
Hoarseness	Yes	No	Slow Urine Stream	Yes	No
Nosebleeds	Yes	No	Abnormal Bleeding	Yes	No
Shortness of Breath	Yes	No	Blood in Stool	Yes	No
Dizziness	Yes	No	Pus in Urine	Yes	No
Chest Pain/Pressure	Yes	No	Yellow Jaundice	Yes	No
Irregular Heartbeat	Yes	No	Depression/Anxiety	Yes	No
Swelling of Feet	Yes	No	Weight Gain	Yes	No
Cough	Yes	No	* How many pounds _____		
Wheezing	Yes	No	Weight Loss	Yes	No
Vomited Blood	Yes	No	* How many pounds _____		

Social Determinate Questions

What's your highest education level? None Less than H.S High School Some College Other: _____

Are you able to care for yourself? YES or NO

Rate your general stress level 0 to 5 ; 5 beginning extremely stressed: _____

Do you have difficulty reading? YES or NO

Do you have transportation difficulties? YES or NO

Do you have concerns about meeting basic needs. (Food, Housing, Heat, etc) ? YES or NO

Dr. KAREN L SMITH, MD, PA, 929 WEST PROSPECT AVE, RAEFORD, NC, 28376 – PHONE: 910-904-1695 – 910-904-1767

AUTHORIZATION TO RELEASE AND OBTAIN CONFIDENTIAL INFORMATION

Client's Full Name: _____ Date of Birth: _____/_____/_____

Medical Record # _____ Social Security Number # _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFOMRATION – 45 CFR Parts 160 and 164; CFR, Part 2; G.S. 122C This form implements the requirements for client authorizations to use and disclose health information protected by the federal health privacy law (45 CFR parts 160, 164), the federal drug and alcohol confidentiality law (42 CFR part 2 and state confidentiality law governing mental health, developmental disabilities and substance abuse services (G.S.122 C).

I, _____ authorize _____
(Client's name or client's legally responsible person or personal representative) (Agency or person authorized to use or disclose the information)

_____
(Agency or person authorized to use or disclose the information address, phone & fax number)

to obtain or disclose to _____
(Agency or person to whom the requested use or disclosure will be made)

_____
(Address of Agency or person to whom the requested use or disclosure will be made)

TYPE OF INFORMATION TO BE OBTAINED OR DISCLOSED

This data shall include: (Client / Guardian Initials by EACH appropriate block)

_____ Complete Medical Records	_____ Diagnosis	_____ Financial Information
_____ Admission Assessment	_____ Case Management Assessment / Notes	
_____ Office Notes	_____ Alcohol / Drug History	_____ Psychological Evaluation
_____ Comprehensive Summary	_____ Legal History	_____ Psychiatric Evaluation
_____ Immunization Record	_____ Person-centered Plans / Plans of Care	
_____ Psychiatrists Progress Notes	_____ NC TOPPS	_____ Discharge Summary
_____ Medication History / Physician's Orders	____ IPRS	_____ Lab results: Specify type: _____
_____ Verbal communication related to treatment	____ NC SNAP	_____ School (attendance, grades, IEP, education)
_____ Any Other Pertinent Information	_____ Insurance Information	_____ Dates of Treatment

I understand this information will be used for: (Client / Guardian Initials by EACH appropriate block)
_____ Insurance / Medicaid / Medicare / IPRS determinations of benefits and billing purposes
_____ To assist in the development of individual service / goals plans
_____ To assist in securing benefits from entitlement programs
_____ Provide data to assist with evaluation / assessment / prescriptive services
_____ Coordination of services between agencies
_____ Other: (Specify) _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION 45 CFR Parts of 160 and 164: 42 CFR, Part 2: G.8. 122C I understand that the information to be released may include information regarding drug abuse, alcohol abuse, sexually transmitted diseases, HIV Infection, AIDS or AIDS related conditions, psychiatric information or physical impairments.

_____

REVOCATION AND EXPIRATION

I understand that, with certain exceptions, I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance on it. The procedure for how I may revoke this authorization, as well as the exceptions to my right to revoke, are explained in KAREN L SMITH'S Privacy Notice, a copy of which has been provided to me.

If not revoked earlier, this authorization expires automatically upon: _____ or one year from the date it is signed, whichever is earlier.

NOTICE OF VOLUNTARINESS

I certify that this authorization is made freely, voluntarily and without coercion. I understand that KAREN L SMITH cannot deny or refuse to provide treatment, payment, enrollment in a health plan or eligibility for benefits if I refuse to sign this authorization, except in limited circumstances, i.e. research related treatment, services provided solely for reason of creating PHI for disclosure to a third (3rd) party.
Signature: _____ Date: _____
Please explain authority of person signing above to act on behalf of Client:_____
Signature of MINOR: _____ Date: _____
(MINORS SIGNATURE ONLY REQUIRED IF MINOR HAS A SUBSTANCE ABUSE DIAGNOSIS)

General Consent of Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point of care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary examinations, testing and treatments. By signing below, you are indicating that (1) you intend that this is consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physicians about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its consents.

Print Name of Patient or Personal Representative **Date:**

_____ _____

Signature of Patient or Personal Representative **Date:**

_____ _____

Signature of Witness **Date:**

_____ _____

Patient Name: _____ DOB: _____

THIS PORTION TO BE COMPLETED WHEN A PATIENT IS UNABLE TO GIVE WRITTEN CONSENT:

We, the undersigned, do verify that the above authorization has been read to the patient and that he/she understands the nature of the release and freely gives his/her verbal consent for release of the information.

Verbal Consent requires signatures of two witnesses

_____ _____
Signature of witness *Date*

_____ _____
Signature of witness *Date*