**East Asheville Family Health Care, PA**
**946 Tunnel Road**
**Asheville, NC, 28805**

**James H. Early, M.D.** **Anne J. Parker, FNP**

# Medical Registration Form

| Patient's Last Name | First | Middle | Title | Other name |
|---|---|---|---|---|
| | | | | |

| Street Address | City | State | Zip | Phone (home) | Cell |
|---|---|---|---|---|---|
| | | | | | |

| Date of Birth | Age | Sex | Marital Status | Social Security No. | Email |
|---|---|---|---|---|---|
| | | | | | |

| Your Occupation | Your Employer | F/T-P/T Self-employed | Work phone |
|---|---|---|---|
| | | | |

| Spouse's Occupation | Spouse's Employer | F/T-P/T Self-employed | Work phone |
|---|---|---|---|
| | | | |

| Health Insurance Provider | Policy Number | Group Number | Co-Payment |
|---|---|---|---|
| | | | |

******Please supply a copy of the front and back of your insurance card.******

| Subscriber's Name | Subscriber's SSN | Date of Birth | Relationship to patient |
|---|---|---|---|
| | | | |

**Clinic Information**

| Previous Doctor | Date of Last Physical Exam | Reason for Choosing this Clinic |
|---|---|---|
| | | |

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize East Asheville Family Health Center or insurance company to release information required to process my claims.

| Patient/Guardian signature | Date |
|---|---|
| | |

**Emergency Contact**

| Name | Relationship to Patient | Home phone | Work Phone | Cell |
|---|---|---|---|---|
| | | | | |

**NOTICE** - Medication list must be accurate. Please provide a list that includes **ALL** of you medications. If your medication list is error and fails to list a controlled substance, that substance **WILL NOT** be prescribed by our practice.

## Medical Information Sheet

**Name**_____**DOB**_____

**Reason for today's appointment**_____

**USE SECOND SHEET FOR COMPLETE LIST IF NEEDED**

**Please list all the medicines (over the counter or prescriptions) that you currently take, along with the dosage and how often you take the medication. No meds taken**

_____

_____

**Check any of your current or past medical problems:**

| | | | | |
|---|---|---|---|---|
| **Anemia** | **Diabetes** | **Heart disease** | **Stroke** | **COPD** |
| **Arthritis** | **Blood clots** | **Thyroid disease** | **Seizures** | **High Blood Pressure** |
| **Asthma** | **Kidney disease** | **Cancer** | **Migraines** | **High cholesterol** |
| **Anxiety** | **Depression** | **Tuberculosis** | **Other** | |

**Do you have any allergies to medication? Please list the medication and describe the reaction.**
**No known allergies**

_____

**Please list all of your surgeries, including dates:** _____

_____

**Family History – (check or write in info)**

| | Age | Alive | Dead | Diabetes | Blood pressure | Cancer | Stroke | Mental Illness |
|---|---|---|---|---|---|---|---|---|
| **Mother** | | | | | | | | |
| **Father** | | | | | | | | |
| **FATHER'S SIDE** | | | | | | | | |
| **Paternal grandfather** | | | | | | | | |
| **Paternal grandmother** | | | | | | | | |
| **MOTHER'S SIDE** | | | | | | | | |
| **Maternal grandfather** | | | | | | | | |
| **Maternal grandmother** | | | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Brother** | | | | | | | | |
| **Sister** | | | | | | | | |

**Do you drink alcohol? Yes/No If so, how much per week/per month?** _____
**Do you use tobacco? Yes/No If so, How much? For how many years?** _____
**Any other drug use**? _____
**Coffee/tea/soft drinks daily?** _____
**Do you exercise? Yes/No If so, what type of exercise?** _____
**Give dates of immunizations/screenings:**

**Influenza vaccine** _____
**Pneumonia vaccine** _____
**Tetanus vaccine** _____
**Gardasil** _____
**Zostavax** _____

**Pap smear**_____
**Colonoscopy** _____
**Mammogram** _____
**Bone density** _____
**PSA** _____

946 Tunnel Road - Asheville, NC 28805 - (828) 298-7981 - FAX (828) 298-6010

# FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your successful treatment. Please understand that payment of your bill is considered a part of your treatment. All patients must read, complete, sign and date our Patient Information form as well as our Financial Policy prior to any treatment. On all subsequent visits, we require all patients to confirm our database information, and to provide the insurance card.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. In accordance with your contract with your insurance provider. CO-PAYS are due at check-in at each appointment, in addition to any outstanding balances that may be on your account from previous visits. Your appointment will be rescheduled if you have an unpaid balance. **WE ACCEPT CASH, CHECKS, MASTERCARD OR VISA.**

RETURNED CHECKS DUE TO NONSUFFICIENT FUNDS (NSF)
Accounts with returned checks due to NSF may be assessed a minimum fee of **$20**, plus any bank charges levied against EAFHC due to NSF checks received from patients.

CASH PAYERS 100% payment in full is due at the time services are rendered. We will not schedule future appointments if there is an unpaid balance on your account.

INSURANCE You are responsible for your (and your dependents) bill and your insurance coverage does not relieve you of this responsibility. This office may accept assignment of insurance benefits; however you are required to pay all co-pays and deductibles at the time of service. You must furnish our office with a copy of your current medical insurance card or we will not be able to file your insurance. Unless this office is a participating provider, your insurance policy is a contract between the insured and the insurance company, and this office is not bound by that contract. If your insurance company has not paid within 45 days, the full balance may be transferred to your responsibility and full and prompt payment will be expected.

OUT OF NETWORK INSURANCE 100% payment in full is due at the time services are rendered. After payment of your account balance, we will file your insurance as a courtesy, and your insurance company will reimburse you. We will not schedule future appointments if there is an unpaid balance on your account.

PRESCRIPTIONS One business day's notice is required for prescription refills. All routine requests require that you call your pharmacy unless a written prescription is needed. To assist in keeping your prescriptions current, please bring all medications with you to your appointments.

There will be a **$20** fee for non-routine prescriptions that are called in locally for acute problems that normally necessitate an office visit. This fee will cover the time of taking symptoms over the phone, reviewing your medical record and medical decision making. An additional fee of **$5** will be assessed for long distance prescription call-ins for all prescriptions (routine as well as non-routine). This charge will not be filed on your insurance. ****NOTICE**** **Medication list must be accurate. Please provide a list that includes ALL of your medications. If your medication list is in error and fails to list a controlled substance, that substance WILL NOT be prescribed by our practice.**

TRANSFER OF MEDICAL RECORDS There will be a charge for a personal copy or the permanent transfer of your records. HealthPort has been contracted by our office to provide this service and will invoice you directly.

COMPLETION OF FORMS There is a separate charge for completion of forms. The price will be determined by the physician based on complexity of the form and time involved in completion. These charges are not covered by insurance and will be billed to your account.

CANCELLATION AND NO SHOW APPOINTMENTS Please notify the office at least 24 hours prior to your appointment time so that other patients can be worked into that time slot. A significant block of time is set aside for a physical exam. If you cannot keep your appointment for a physical, we require a 48-hour advance notice of cancellation. There will be a **$25** charge for physical appointments cancelled with less than 48 hours notice and "no-show" physical appointments. This charge cannot be filed with insurance. You will be responsible for this charge.

COLLECTION In the event that you default on all or any portion of your financial obligation, your account may be turned over to a collections agency. At that time, charges will be added for attorney and collection fees incurred in the collection of said debt.

NOTICE OF FINANCE CHARGE Effective May 1, 2010, an APR of 12% (1% monthly) will be assessed on the total unpaid account balance when any part of the balance is 30 days or more past due.

I HAVE READ, UNDERSTAND AND AGREE TO ABIDE BY THE POLICIES OF EAST ASHEVILLE FAMILY HEALTH CARE AS OUTLINED ABOVE.

Patient and/or Guardian Printed Name

Date

Signature of Patient/Guardian

Signature of Witness

Modified 5/14/2014