PIEDMONT INTERNAL MEDICINE

PATIENT INFORMATION

Patient Name: _____ **Today's Date:** _____

Social Security Number: (Last 4 Digits)_____ **Birth Date:** _____ **Gender:** ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Home Address: _____

Phone Numbers: Primary: _____ **Work:** _____ **Email:** _____

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Race/Ethnicity: ☐ White/Caucasian ☐ Black/African ☐ American ☐ Asian ☐ Hispanic/Latino ☐ Other: _____

Emergency Contact Name: _____ **Phone Number:** _____
Relationship to Patient: _____

- **Whom may we thank for referring you?** _____

EMPLOYMENT INFORMATION

Employer: _____ **Position:** _____

Employer's Address: _____

PREFERRED PHARMACY

Pharmacy Name: _____ **Phone:** _____

Pharmacy Address: _____

INSURANCE INFORMATION

Responsible Party: If patient check here:

Name: _____ **Date of Birth:** _____ **Relationship:** _____

Phone Number: _____ **Address:** _____

Primary Insurance Co: _____ **Group Number:** _____

Subscriber's Name: _____ **ID Number:** _____

Relationship to Patient: _____ **Date of Birth**: _____ **Ins. Phone Number:** _____

Secondary Insurance Co: _____ **Group Number:** _____

Subscriber's Name: _____ **ID Number:** _____

Relationship to Patient: _____ **Date of Birth:** _____ **Ins. Phone Number:** _____

(PLEASE BRING YOUR INSURANCE CARD AND PHOTO ID TO ALL APPOINTMENTS)

PIEDMONT INTERNAL MEDICINE

Medical History Questionnaire

Name:_____ **Date of Birth**: _____

List main reason for today's visit: _____

_____

List any other active problems (include treating physician if applicable): _____

_____

_____

Allergies and reaction: _____

Medications and dosages (please include supplements): _____

_____

_____

Do you feel you have problems with sleep, snoring or daytime sleepiness? ☐ Yes ☐ No
Would you like to speak with us about this? ☐ Yes ☐ No

Past medical illnesses (Please place a check by all which applies):

☐ Alcohol/Drug Abuse	☐ Cancer	☐ Heart murmur	☐ STD(type)
☐ Anemia	☐ Crohn's disease	☐ Hepatitis B/C	☐ Sickle cell disease
☐ Aneurysm	☐ COPD/Emphysema	☐ High cholesterol	☐ Sleep apnea
☐ Anxiety disorder	☐ Depression	☐ HIV	☐ Stomach ulcer
☐ Arthritis	☐ Diabetes	☐ Hypertension	☐ Stroke
☐ Asthma	☐ Glaucoma	☐ Kidney disease	☐ Thyroid disease
☐ Blood disorder	☐ Gout	☐ Kidney stones	☐ Tuberculosis
☐ Blood clot	☐ Hay fever	☐ Liver disease	☐ Positive TB skin test
☐ Blood transfusion	☐ Heart disease	☐ Seizure	☐ Ulcerative colitis

Other: (please specify) _____

Past Operations/Procedures and/or Hospitalizations (please include date): _____

_____

_____

Family history (please indicate major medical problems; If deceased, please indicate cause of death):

Maternal Grandmother:_____

Maternal Grandfather:_____
Paternal Grandmother:_____
Paternal Grandfather:_____
Mother:_____

Father: _____
Siblings: _____
Children: _____

Social History

Occupation:_____ Marital Status:_____ Children: _____
Alcohol Use: Yes ☐ No ☐ How often:_____ Quantity:_____
Tobacco Use: Yes ☐ No ☐ Pack per day:_____ How many Years: _____
Former Smoker: Yes ☐ No ☐ Pack per day:_____ Year quit: _____
Other Tobacco/Nicotine: Yes ☐ No ☐ Type:_____ Quantity:_____
Other Drugs: Yes ☐ No ☐ If yes, please specify: _____
Exposure to asbestos or other hazardous material: Yes ☐ No ☐ If yes, please specify: _____
Do you have a living will? Yes ☐ No ☐
Healthcare proxy: Yes ☐ No ☐ If yes, please indicate Name:_____
Relationship: _____

Health Maintenance

Last known Menstrual cycle:_____ Last known Pap Smear: _____
Last known Mammogram:_____ Last known Colonoscopy: _____
Last known Prostate Cancer Screening:_____ Last Bone Density scan: _____

Date of Last Immunizations:

Pneumonia:_____ Flu:_____ Tetanus/TD/Tdap:_____
Hepatitis A:_____ Hepatitis B: _____

Review of Systems: (Please place a check by all which applies):

☐	Weight Gain	☐	Weakness	☐	Insomnia	☐	Blood in vomit
☐	Persistent Cough	☐	Fainting	☐	Mood Swings	☐	Bowel Changes
☐	Blood in Stool	☐	Frequent urination	☐	Difficulty swallowing	☐	Runny nose
☐	Headache	☐	Tremor	☐	Nausea	☐	Feeling cold
☐	Weight loss	☐	Fatigue	☐	Change in vision	☐	Back pain
☐	Fever	☐	Change in exercise Tolerance	☐	Vaginal discharge/bleeding		
☐	Chest Comfort	☐	Penis Discharge	☐	Anxiety	☐	Blood in sputum
☐	Difficult urinating	☐	Breast pain	☐	Change in hearing	☐	Nipple discharge
☐	Memory Loss	☐	Leg swelling	☐	Depression	☐	Short of breath
☐	Night Sweats	☐	Pain with intercourse	☐	Heartburn	☐	Diarrhea
☐	Breast Lump	☐	Trouble breathing	☐	Skin rash	☐	Nose bleed
☐	Leg pain	☐	Palpitations	☐	Feeling hot	☐	Constipation
☐	Dizziness	☐	Numbness/Tingling				

Patient Signature:_____ Date: _____

Reason Patient is Unable to Sign:_____ Date:_____

PIEDMONT INTERNAL MEDICINE

PATIENT FINANCIAL AGREEMENT

Welcome to Piedmont Internal Medicine. We are dedicated to making sure that our patients are provided with exceptional medical care. **We strongly encourage each patient to contact their insurance company to confirm their doctor is a participating provider in their plan.**

As a service to our patients, we are currently enrolled in numerous Managed Care plans. However, it is impossible for the practice to know all the requirements of each individual plan. **It is the patient's responsibility to be aware of the parameters of your individual plan and to notify the office of any changes or restrictions.** Any charges which are accrued because of failure of notification will be the responsibility of the patient. If insurance cannot be verified prior to each appointment, payment will be due at the time of service.

Patients who have a HMO policy must ensure their physician is listed on their insurance card. If not, the insurance provider will not cover the services provided. Any unpaid charges will be the patient's responsibility.

At Piedmont Internal Medicine, PC we provide diagnostic procedures, examinations and medical treatment including laboratory work. As a courtesy, we file charges directly to your insurance. At times, it is required that we send medical records to assist with payment of these charges.

Please be aware some of the services billed to your insurance may result in charges to you depending on your individual insurance plan coverage. Please take the time to acquaint yourself with your insurance policy.

Please note Piedmont Internal Medicine, PC follows all Federal laws. We are not able to rebill due to services not being covered by your insurance policy. If you receive a bill from an outside facility such as LabCorp, Quest, or Piedmont Hospital, you will need to contact them directly.

Self-pay patients are required to pay at the time services are rendered. An initial deposit of 150.00 will be required at Check In. Upon check out charges will be reconciled. As a courtesy, Piedmont Internal Medicine, PC offers a self-pay rate on same date services provided, including most laboratory services, only if charges are paid the day of services.

We contact every patient to remind them of their appointment. We ask all patients to give at least 24 business hour advanced notice in canceling or rescheduling an appointment. Failure to do so will result in a fee of $75.00 for an Office Visit, $150.00 for a Physical Exam/Annual Wellness Visit and $150.00 for an Echocardiogram. This will be your responsibility to pay.

Any **returned check** will incur a $35.00 charge to cover bank charges associated with the returned check in addition to the amount of the check. NSF checks must be redeemed with certified funds and check will no longer be accepted as payment.

An upfront fee of $35.00 will be collected for administrative tasks such as completing disability forms, FMLA, biometric screening form, medication prior authorizations and some medical records request. These tasks may require up to ten days to complete.

If any bills are acquired, it must be paid within 30 days of receipt. If you are unable to pay your balance, please contact the billing office to make payment arrangements. Any balance left unpaid nor under arrangements may be sent to a collection agency. If your account is sent to collections, there will be a $30.00 collection fee added to the total outstanding balances.

I acknowledge I have read and understand the policies above. I accept the rights and responsibilities outlined within them.

Patient/Guardian Signature:_____ Date: _____

PIEDMONT INTERNAL MEDICINE

CONSENT AND RELEASES

Consent for Treatment

I,_____, hereby voluntarily consent to outpatient care at Piedmont Internal Medicine, PC encompassing routine diagnostic procedures, examination and medical treatment including, but not limited to, routine laboratory work (such as blood, urine, and other studies), and administration of medications prescribe by the physician. I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the physicians and their assistants, including nurse practitioners, physician assistants, medical assistants, or their designees as is necessary in the physician's judgment.

Notice of Patient Privacy Consent (HIPAA)

☐ I have been provided with a copy (electronic and/or printed copy) of the practice's Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information. (The Notice of Patient Privacy Consent is posted on our website at www.PiedmontInternalMed.com for your convenience.)

Authorized Release of Medical Information

There are times where the physicians and employees of Piedmont Internal Medicine need to contact you. Our primary method is through our "My Chart" patient portal, however, circumstances may require us to contact you via mail, email, telephone, voice mail, and/or text messaging. Please check the additional approved methods of how we may contact you regarding your personal and private health information. Please note, you may change or revoke your authorization approvals at any time. ***Check all that apply:***

☐ Home Answering Machine ☐ Text Message ☐ Work Voice Mail ☐ Mailing Address
☐ Cell Phone Voice Mail ☐ Personal Email ☐ Work Email

I authorize the release of medical information to the following:_____

_____

Name and Relationship *Name and Relationship*

Lifetime Medicare Authorization & Consent for Medicare Patients Only

☐ I certify that the information given by me in applying for payment under Title SVIII and /or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. Please note Federal Law requires us to collect your yearly deductible and co-insurance amounts. If you have a secondary insurance, we will bill your secondary insurance after Medicare pays the requested amount. I understand that I am responsible for my health insurance deductible and coinsurance.

Medigap Authorization Statement

☐ I authorize any holder or other information about me to release Piedmont Internal Medicine, P.C. any information needed for this or a related Medigap claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Consent for Use, Disclosure of Patient Information for the purposes of Treatment, Payment, and Healthcare Operations

☐ I hereby consent to Piedmont Internal Medicine, PC using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's health care operations. I also consent to Piedmont Internal Medicine, PC using or disclosing my protected health information for treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider or entity. I further consent to the disclosure of my protected health information for another provider or health care entity to conduct health care operations

Health Information Exchange

☐ Health information exchange allows health care providers to share health care information about patients electronically for several purposes, such as treatment, quality assurance and state law reporting requirements. I understand that if I go to the Practice for treatment, the physicians and/or their staff may get a copy of my medication history and other health care information electronically through various health information exchange connections with other health care providers. **I understand I may request that my health care information not be shared through electronic health information exchange by following the directions in the Practice's Notice of Patient Privacy Practices.**

Terminating Services

☐ All the providers at Piedmont Internal Medicine value a meaningful and productive relationship with our patients. Unfortunately, there are occasions when this is no longer feasible. Please be advised that the Practice reserves the right to terminate the provider/patient relationship for the following reasons:

1. Multiple cancellations or missed appointments.
2. Medical Non-Compliance, including violation of Therapeutic Drug Agreement.
3. Failure to comply with practice policies, including yearly physical exams.
4. Rude, abusive behavior, use of obscene language, mistreatment of staff in person or on the phone.
5. Failure to pay a debt/account sent to collections

If the relationship is terminated, you will be notified in writing. Your provider will provide emergency medical care for 30 days following the date of the written notice and will send medical records to a new provider with a written release.

COVID-19

☐ I understand that the 2019 novel coronavirus, which causes the disease COVID-19, has been declared a pandemic by the World Health Organization, is extremely contagious and is believed to be spread by person-to-person contact. I recognize the staff of Piedmont Internal Medicine has put in place reasonable preventative measures aimed at reducing the spread of COVID-19. However, I acknowledge and accept the risk of becoming infected by virtue of seeking services in-person at Piedmont Internal Medicine.

Patient Signature: _____Date: _____

PIEDMONT INTERNAL MEDICINE

Piedmont Internal Medicine
Medication Prior Authorization Request

Patient Name: ______________________________ **MRN/SSN:** __________________________
Date of Birth: ____________________ **Phone # (best reached):** _________________________

I, ________________________________ request Piedmont Internal Medicine, PC to obtain a prior authorization from my insurance for a prescription medication

Authorization Needed for:

Name of Prescription Medication (s): (please specify: name, quantity and dosage)
____

Insurance to Be Contacted:

Name of Insurance Company: ____
Member Identification Number: ____

PLEASE NOTE: Medication prior authorization initiation and completion time will be approximately 5-7 days depending on your insurance company.

Authorization:

By signing this form, I am acknowledging I will be charged an administration fee for completing the requested medication prior authorization. This fee will not be covered by my insurance and I will need to complete payment prior to the prior authorization being initiated. Additionally, I am aware the insurance may approve or deny this medication based on my insurance plan's guidelines. This associated fee does not include second level appeals or future reauthorizations.

Number of Authorizations	Fee Associated
1-2	$35.00
3	$40.00
4+	$50.00

Signature: ____**Date:**__________________________________
(Patient/Legally Authorized Representative)

- -

Information below this in line is to be shredded after processing

Name on Card: __________________________________ Credit Card Number: ____________________________

Expiration Date: ________________________________ CVS Number: ____________________________________

Charge Amount: ____