MATTHEWS INTERNAL MEDICINE

434 N. Trade Street, Suite 104
Matthews, NC 28105
704-246-3936 (office)
704-771-1931 (fax)

PATIENT DEMOGRAPHIC FORM

(THIS FORM IS TO BE UPDATED YEARLY OR WITH ANY INFORMATION CHANGES)

PATIENT INFORMATION

Patient Name_____ Patient's Social Security Number:_____

Date of Birth:_____ Sex: M F Marital Status: S M D W (Circle one) Race_____ Ethnicity_____

Language Preference if not English:_____ Other communication issues? N Y (what) _____

Street Address:_____ Apt No:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ work Phone: (___) _____

Cell/Pager Phone: (_____) _____ Email Address:_____

Emergency Contact Name: _____ Emergency Contact Address: _____

Emergency Contact Phone: _____

Employer's Name: _____ Work Phone #:_____

Employer's Address:_____

City: _____ State_____ Zip Code:_____

Insurance Info: Name of insurance_____ Policy #_____ Group # _____

Name of Pharmacy/Location that you use_____

How did you hear about us?_____

I hereby authorize my insurance benefits to be paid directly to MIM. I understand I am responsible for all charges including any added costs incurred due any effort to collect for services rendered. I realize I am responsible to pay for non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.

Signature of Responsible Party:_____ Date:_____

Patient Name_____ DOB_____

MATTHEWS INTERNAL MEDICINE

434 N. Trade Street
Suite 104
Matthews, NC 28105

Patient Consent and Authorization for Treatment

Consent for Routine Treatment: I hereby consent to the rendering of medical care, which may include routine diagnostic procedures and such treatment as my physician considers to be necessary. I understand that:

A. It is the policy of Matthews Internal Medicine, that, absent emergency or extraordinary circumstances, no substantial procedures are to be performed upon me unless and until I have been provided sufficient information to have an understanding of the procedures or treatments involved and informed and informed of the usual and most frequent risks and hazards inherent in the proposed procedures or treatments as well as an opportunity to discuss them with my physician to my satisfaction:
B. I have the right to consent, or to refuse consent, to any proposed procedure or therapeutic course.

Authorization for Release of Medical Information: Matthews Internal Medicine is authorized to furnish any medical information relating to my treatment to my insurance company, health maintenance organization, or charitable agencies and their agents, my employer and professional review organizations with whom I may have coverage or who may be assisting in payment or evaluation of my medical care for the purpose of collecting payment therefrom. I acknowledge and grant access to students or faculty members in healthcare education programs to my medical records, observe or participate in my treatment, or utilize data obtained from my medical records as authorized by Matthews Internal Medicine. I authorize Matthews Internal Medicine to release any medical information to any licensed physician or medical facility to which I may be referred or transferred for further medical care. I understand that this authorization will not expire, but I may revoke this authorization, in writing and witnessed, at any time, except to the extent that action has already been taken in reliance on this authorization prior to it revocation.

Authorization Medicare and Medicaid Information: I certify that the information provided to me in applying for payment to Release under Titles V, XVIII and/or XIX of the Social Security Act is correct. I understand that healthcare services paid for under Medicare and Medicaid are subject to review by professional review organizations, which may recommend denial of payment if my medical condition does not warrant continued care. I hereby authorize those agencies responsible for determining eligibility under these programs to provide to Matthews Internal Medicine any information relating to the determination of my eligibility. I authorize Matthews Internal Medicine to submit a claim to Medicare for payment. I request that payment of nay bills for services furnished under the Medicare program be made to either me or Matthews Internal Medicine as the individual claim form and Matthews Internal Medicine may direct.

Patient Name_____ DOB_____

Advance Billing Notice/Waiver of Liability: Your physician, after history and physical examination, may recommend or advise certain tests and/or studies which Medicare, Medicaid or other third party payer may determine to be medically unnecessary, (for Medicare as defined under Section 18/62(a) 1 of the Social Security Act). If your physician or other healthcare professional of Matthews Internal Medicine have reason to believe that Medicare, Medicaid or other third party payer may deny coverage, you will be so informed and requested to sign an Advanced Billing Notice of Waiver of Liability acknowledging you have been informed of such information and are agreeing to pay Matthews Internal Medicine for these services if Medicare, Medicaid or other third party payer deny benefit payment. Your physician will only recommend studies and/or tests, which he/she deems to be in your best interest.

Medicare Lifetime Beneficiary Authorization (Applies to Medicare Patients Only): I hereby request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by or in Matthews Internal Medicine, including physician services. I authorize any holder of medical or other information about me to release to CMS and its agents any information needed to determine these benefits or benefits for related services.

Authorization to File Insurance Automatically: I hereby request and authorize Matthews Internal Medicine to file claims automatically after services have been rendered me. Individual requests will not be made, I will advise in writing to Matthews Internal Medicine any alteration to this request and authority.

Assignment to File Insurance Automatically: I hereby authorize payment directly to Matthews Internal Medicine for medical or surgical benefits otherwise payable to me including major medical insurance. I understand that I am financially responsible to Matthews Internal Medicine for its services in connection with treatment rendered during encounters, and such excess amount may be applied to payment for any other indebtedness due by me for other treatment rendered and the balance, if any remains, shall be paid to me.

PAYMENT:

I agree to pay all charges for medical care rendered by Matthews Internal Medicine to me. I guarantee the full and completer payment of all charges for medical care rendered by Matthews Internal Medicine and its physicians. This is a guarantee of payment and not merely of collection, and I agree to be directly responsible for the payment of all charges. If I fail to pay any such charges due Matthews Internal Medicine and it becomes necessary for them to institute collection efforts against me, I agree to pay Matthews Internal Medicine all costs of collection thereof, including reasonable attorney's fee incurred in connection to release and obtain credit information from the are Credit Bureau and Collection Agency.

I HAVE READ, AND UNDERSTAND AND AGREE TO THE PROVISIONS PERTAINING TO MY RELATIONSHIP WITH MATTHEWS INTERNAL MEDICINE.

_____ _____

Patient Signature Date

MATTHEWS INTERNAL MEDICINE
Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

_____ is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Other_____
☐ Other person (s) (provide name and phone number)	☐ Financial ☐ Medical
☐ Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: _____
☐ For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
☐ Photo of patient received by patient or legal guardian ☐ Photo taken by staff (Example: pre/post procedure) ☐ Other	☐ May be posted in office ☐ May be posted on website ☐ Other_____

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

Revised Oct 2014

Authorization to Release Health Information

Patient Information:

Name of Patient _____ Date of Birth _____

Address_____

City, State, Zip _____Phone _____

Entity who will release the information:

Name _____

Address_____

City, State, Zip _____Phone _____ Fax_____

☐ Entire record ☐ Financial records ☐ Office visit notes

☐ Diagnostic Studies: ☐ On site record review by the patient

Entity or person who will receive the information:

Name: **Matthews Internal Medicine**

Address: **434 N. Trade Street, Suite 104**

City, State, Zip: **Matthews NC 28015 Phone: 704-246-3936 Fax: 704-771-1931**

☐ **Send the information electronically. Email address: _____**

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV.

_____Date _____

Signature of Patient or Personal Representative

_____

Description of Personal Representative's Authority (attach necessary documentation)

Revised May 2014

MATTHEWS INTERNAL MEDICINE
FINANCIAL POLICY

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions, please discuss them with our billing staff or office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment.

Insured Patient

- Copays, Co-insurance and Deductibles are due at the time of service. For your convenience, we accept cash, check and most major credit cards.
- In the event that your insurance carrier determines a service to be "non-covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

Non-Insured Patients

- Non-insured patients will be required to pay all charges at the time of service at a discounted rate.

Established patient with an account balance are offered financial arrangements if the need arises. If the terms are not met by the patient, the account will be deemed delinquent and collection action will be taken.

All Patients

- **Disability/FMLA Forms**: A $15 fee will apply to assist in the completion of disability forms.
- **Returned Checks**: A $25 fee will apply to all checks returned to our office as "unpaid". Payment for future services may be required by cash or credit card.
- **Cancelled/Missed Appointments**: A $25 fee may apply for patients that repeatedly miss appointments. A $25 fee may apply to patients that cancel appointments less than 24 hours in advance of the scheduled appointment. We also reserve the right to terminate any new patient who misses their initial appointment and/or any patient who misses three consecutive appointments.
- **Medical Records**: A fee may be charged for providing copies of medical records.

I have read and fully understand the policies of this office regarding payments and insurance. I agree to pay for services and tests not covered by my insurance plan. I understand that I am responsible for following my insurance plan's regulations, policies and procedures.

_____ _____

Signature: Patient or Guarantor Date

_____

Printed Name: Patient or Guarantor

Patient Name _____ DOB _____

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A. It is the policy of Matthews Internal Medicine, that, absent emergency or extraordinary circumstances, no substantial procedures are to be performed upon me unless and until I have been provided sufficient information to have an understanding of the procedures or treatments involved and informed of the usual and most frequent risks and hazards inherent in the proposed procedures or treatments as well as an opportunity to discuss them with my physician to my satisfaction:

B. I have the right to consent, or to refuse consent, to any proposed procedure or therapeutic course.

Authorization for Release of Medical Information: Matthews Internal Medicine is authorized to furnish any medical information relating to my treatment to my insurance company, health maintenance organization, or charitable agencies and their agents, my employer and professional review organizations with whom I may have coverage or who may be assisting in payment or evaluation of my medical care for the purpose of collecting payment therefrom. I acknowledge and grant access to students or faculty members in healthcare education programs to my medical records, observe or participate in my treatment, or utilize data obtained from my medical records as authorized by Matthews Internal Medicine. I authorize Matthews Internal Medicine to release any medical information to any licensed physician or medical facility to which I may be referred or transferred for further medical care. I understand that this authorization will not expire, but I may revoke this authorization, in writing and witnessed, at any time, except to the extent that action has already been taken in reliance on this authorization prior to its revocation.

Authorization Medicare and Medicaid Information: I certify that the information provided by me in applying for payment to Release under Titles V, XVIII and/or XIX of the Social Security Act is correct. I understand that healthcare services paid for under Medicare and Medicaid are subject to review by professional review organizations, which may recommend denial of payment if my medical condition does not warrant continued care. I hereby authorize those agencies responsible for determining eligibility under these programs to provide to Matthews Internal Medicine any information relating to the determination of my eligibility. I authorize Matthews Internal Medicine to submit a claim to Medicare for payment. I request that payment of nay bills for services furnished under the Medicare program be made to either me or Matthews Internal Medicine as the individual claim form and Matthews Internal Medicine may direct.

Patient Name _____ DOB _____

Advance Billing Notice/Waiver of Liability: Your physician, after history and physical examination, may recommend or advise certain tests and/or studies which Medicare, Medicaid or other third party payor may determine to be medically unnecessary, (for Medicare as defined under Section 1862(a)1 of the Social Security Act). If your physician or other healthcare professional of Matthews Internal Medicine have reason to believe that Medicare, Medicaid or other third party payor may deny coverage, you will be so informed and requested to sign an Advanced Billing Notice of Waiver of Liability acknowledging you have been informed of such information and are agreeing to pay Matthews Internal Medicine for these services if Medicare, Medicaid or other third party payor deny benefit payment. Your physician will only recommend studies and/or tests, which he/she deems to be in your best interest.

Medicare Lifetime Beneficiary Authorization (Applies to Medicare Patients Only): I hereby request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by or in Matthews Internal Medicine, including physician services. I authorize any holder of medical or other information about me to release the Healthcare Financing Administration (HICFA) and its agents any information needed to determine these benefits or benefits for related services.

Authorization to File Insurance Automatically: I hereby request and authorize Matthews Internal Medicine to file claims automatically after services have been rendered me. Individual requests will not be made. I will advise in writing to Matthews Internal Medicine any alteration to this request and authority.

Assignment of Insurance Benefits (not including Medicare): I hereby authorize payment directly to Matthews Internal Medicine for medical or surgical benefits otherwise payable to me including major medical insurance. I understand that I am financially responsible to Matthews Internal Medicine for its services in connection with treatment rendered during encounters, and such excess amount may first be applied to payment for any other indebtedness due by me for other treatment rendered and the balance, if any remains, shall be paid to me.

PAYMENT:

I agree to pay all charges for medical care rendered by Matthews Internal Medicine to me. I guarantee the full and complete payment of all charges for medical care rendered by Matthews Internal Medicine and its physicians. This is a guarantee of payment and not merely of collection, and I agree to be directly responsible for the payment of all charges. If I fail to pay any such charges due Matthews Internal Medicine and it becomes necessary for them to institute collection efforts against me, I agree to pay Matthews Internal Medicine all costs of collection thereof, including reasonable attorney's fees incurred in connection to release and obtain credit information from the area Credit Bureau and Collection Agency.

I HAVE READ, AND UNDERSTAND AND AGREE TO THE PROVISIONS PERTAINING TO MY RELATIONSHIP WITH MATTHEWS INTERNAL MEDICINE.

_____ _____

Patient Signature Date

MATTHEWS INTERNAL MEDICINE

Acknowledgement of Receipt
Of Notice of Privacy Practices

Patient Name & Address: _____

_____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ☐ An emergency existed & a signature was not possible at the time.
- ☐ The individual refused to sign.
- ☐ A copy was mailed with a request for a signature by return mail.
- ☐ Unable to communicate with the patient for the following reason:

  _____
- ☐ Other: _____

  _____

Prepared By _____

Signature _____

Date _____

MATTHEWS INTERNAL MEDICINE

Patient: _____ Date of Birth: _____

Welcome to Matthews Internal Medicine. Please carefully review our office policies.

Office Policies

- It is our policy to request co-pays, co-insurance and deductible payments for services at the time they are rendered.
- If we do have a contract with your insurance company, we will file your claim as a courtesy to you. Please keep in mind however, that you are responsible for all charges. You will also be responsible for obtaining and keeping current authorizations which are required by your insurance company.
- If you cannot keep your appointment, please call our office within 48 hours to inform us.
- If the patient is a minor, (any patient younger than eighteen) a parent or guardian must be present at the time of visit.
- Insurance companies only pay for what they consider medically necessary. Every insurance company has its own policies and these may change from time to time and we cannot be responsible for assuring that the procedure you are requesting will be covered. If your insurance company does not cover the procedure, you will be responsible for the charge.
- Prescription refills – you may receive a prescription for a medication during your visit. The provider will indicate whether there is a refill available on this medication. If you need to have the medication refilled, first check with the pharmacy to see if there are any refills remaining on the original prescription. If not, you may call our office to request a refill. If the refill is approved, we will notify you within 48-72 hours of receiving the request. To receive a prescription refill, follow up appointments much be kept.

Thank you for allowing us to participate in your healthcare needs.

I have read the above and agree to abide by these office policies.

_____ _____

Signature of Patient (or Power of Attorney) Date