Uptown Family Practice

How Did You Hear About Carolina Health Centers?

(Please Check One of the Following)

- ○ Family Member, Friend, or Co-Worker
- ○ Newspaper
- ○ Telephone Book
- ○ Health Fair or Other Community Event
- ○ Radio
- ○ Other: ______________________________
  ____
  ____

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TWO-WAY CONSENT FOR RELEASE OF MEDICAL INFORMATION/RECORDS:

I authorize ongoing communication and all my records (including office notes, x-ray, and pathology reports, laboratory reports, hospital reports and all other records) to be shared between Carolina Health Centers, Inc. and the below-named facility:

Facility Name: ______________________________
Provider's Name: ______________________________
Address: ______________________________
____
Phone #: ____________________ Fax #: ____________________

Additionally, I authorize the above-named facility to communicate with and share records with Carolina Health Centers, Inc.

I am aware of and specifically waive any privilege regarding the following information which may or may not be contained in these records:

1. *Communications between patient and psychiatrist and/or psychologist.*
2. *Medical information concerning alcohol and drug dependency or treatment.*
3. *Medical information concerning HIV infection status or AIDS.*

I authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse or dependency or treatment and HIV/AIDS confidential information that is needed for any utilization review or quality assurance activities. The assignment will remain in effect until revoked by me in writing addressed to Carolina Health Centers, Inc or for one year whichever comes first.

Patient Name: ______________________________ SS#: ____________________
Personal Representative: ____________________ Relationship: ____________________
Address: ______________________________ DOB: ____________________
______________________________ Phone #: ____________________

Signature: ______________________________ Date: ____________________

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the disclosure of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Revised 3/2021

Patient Registration Form

Account #__________________

Name on File with Insurance:________________________________ SSN :______________________

Preferred Name:________________________________ Suffix:___ Date of Birth:________________

Patient's Address:____

Patient's City, State, Zip:____

Contact Information	Emergency Contact
Please check your PRIMARY contact number Home Phone:__________________________ Cell Phone:__________________________ Work/Other Phone:______________________ Email: ______________________________	Name:________________________________ Phone #:______________________________ Address:______________________________ City, State,Zip:__________________________ Relationship to Patient:_________________
Would you like to sign up for MyChart to access your health records and receive important information? ***YES***__________ ***NO***__________ ***Sign up via Email***__________***or Text***________	***Please keep in mind this person may be contacted if we can not reach you directly for appointment reminders, lab results, or referral appointments.***

Insurance Information

Insurance	Guarantor Account (Responsible Party)
☐ Medicare ☐ Medicaid ☐ United Healthcare ☐ Blue Cross Blue Shield ☐ Blue Choice ☐ Cigna ☐ Other:__________________________	Name:________________________________ Phone #:______________________________ Address:______________________________ City, State, Zip:__________________________

Policy 1:________________________________ Policy 2:____________________________

Effective Date:____________________________ Effective Date:________________________

Card Holders Sex:____Male ____Female Card Holders Sex:____Male ____Female

Card Holders Birthdate:_____________________ Card Holders Birthdate:_________________

Copay Amount $___________________________ Copay Amount $_______________________

Patient Financial and Demographic Information

Account #________________

Financial Information

Sliding Fee Scale

Carolina Health Centers, Inc. is committed to removing barriers that might limit access to receiving quality care in an appropriate primary care medical home. One prevalent barrier is the lack of adequate third party coverage and/or insufficient financial resources to pay for care; therefore, it is the policy of Carolina Health Centers, Inc. to offer discounted care on a sliding fee scale to patients who are eligible based on income and family size. We are required to charge for all services. However, charges may be adjusted according to your income and the number of family members.

Are you interested in applying for sliding fee at this time?

______Yes I would like an application at this time ______No I do not wish to apply

Household Income Survey (FPL)

How many people (including yourself) are supported by the annual income:________________________

What is the estimated total household annual income:____________________

Demographics

Please select one box from each of the following sections. The following information is for demographic purposes only and will not affect your care.

Employment Status
- Full Time ☐
- Part Time ☐
- Unemployed ☐
- Student ☐
- Retired ☐

Additional
- Veteran ☐
- Homeless ☐
- Migrant ☐
- Seasonal ☐

Ethnicity
- Hispanic/Latino ☐
- Non-Hispanic/Latino ☐

Marital Status
- Single ☐
- Married ☐
- Partnered ☐
- Divorced ☐
- Separated ☐
- Widowed ☐

Preferred Language
- English ☐
- Spanish ☐
- French ☐
- Other ☐

Race
- Black African American ☐
- Asian ☐
- American Indian/Alaskan Native ☐
- Native Hawaiian/Pacific Islander ☐
- White ☐

Sexual Orientation
- Lesbian or Gay ☐
- Straight ☐
- Bisexual ☐
- Something Else ☐
- Don't Know ☐
- Chose not to disclose ☐

Gender at Birth
- Male ☐
- Female ☐

Gender Identity
- Male ☐
- Female ☐
- Transgender Male (female to male) ☐
- Transgender Female (male to female ☐
- Other ☐
- Chose not to disclose ☐

Signature:______________________________________ Date:______________________________

HEALTH HISTORY/REVIEW OF SYSTEMS

NAME: ______________________________ AGE:_______DATE:__________ CHART#:____________

Primary Care Provider: ______________________________

Hospitalizations
And Surgeries: ______________________________

Medical Problems: ______________________________

Medications: ______________________________

Allergies: ______________________________

MEDICAL SYMPTOMS: CIRCLE ALL THAT APPLY

General	Use of Tobacco (past or present), Alcohol, Caffeine, or Drugs; Chills; Dizziness; Fainting; Fever; Sweats; History of Cancer; Weight Change; Recurrent Headaches; Anemia; Transfusions; Exposure or Risk of AIDS; Any Exercise? Yes/No Last Tetanus Booster: ____________ Last Pneumovax: ____________
Eyes	Crossed Eyes; Double Vision; Pain; Blurred Vision; Glaucoma; Red Eyes
Ears	Earache; Discharge; Loss of Hearing; Ringing in Ears
Nose/Throat	Nosebleeds; Thyroid Problems; Sinus Trouble; Hay Fever; Hoarseness; Teeth or Gum Problems
Cardiovascular	Chest Pain; High Blood Pressure; Irregular Heart Beat; Poor Circulation; Murmur; Heart Attacks; Heart Disease; Shortness of Breath; High Cholesterol
Respiratory	Chronic Cough; Asthma; Emphysema; Coughing up Blood; Pneumonia; Wheezing; Night Sweats
Gastrointestinal	Poor Appetite; Bowel Changes; Constipation; Diarrhea; Nausea; Ulcers; Rectal Bleeding; Liver Disease; Jaundice; Hepatitis; Gallbladder Disease; Hemorrhoids; Blood in Stools; Dark or Black Stools
Genitourinary	Blood in Urine; Painful Urination; Difficult Urination; Prostate Problems; Kidney Stones; Venereal Disease; Sexual Difficulties
Musculoskeletal	Arthritis; Gout; Fractures; Chronic Back Pain; Injuries
Neurologic	Confusion; Head Injury; Numbness; Seizures; Fainting; Stroke; Dizziness
Psychiatric	Anxiety; Depression; Drug Addiction; Suicide Attempt; Sleeping Difficulties; Marital Problems
Endocrine	Diabetes; Lethargy or Fatigue; Heat or Cold Intolerance; Thyroid Disease
Skin Diseases	Dry Skin; Skin Cancers; Sores that Don't Heal; Changing Moles
Gynecological (females only)	Last Pap Smear:_______Last Mammogram;_______# of Pregnancies:________# of Births:________ Birth Control Method: None – Pill – Condoms – Diaphragm – Rhythm – IUD – Shots – Tubal – Vasectomy-Other Irregular of Painful Periods; Bleeding Between Periods or after Sex
Family History	Circle Illnesses that Parents or Siblings Have or Have Had: Diabetes; Heart Disease; Hypertension or High Blood Pressure; Cancer; Alcohol Abuse; Strokes; Asthma; Depression; Tuberculosis, Glaucoma

Other Comments

______________________________ ______________________
Provider Signature DATE

Statement of Income (Sliding Fee Application)

I currently do not have any income. I am (check appropriate box):

___ **Unemployed**
___ **Stay at home parent or guardian**
___ **Retired without a pension**
___ **Student**
___ **Other** ______________________________

Signature____ **Date**_______________________

SLIDING FEE VERIFICATION FORM

NAME (First, Middle, Last)	RELATION TO YOU	Date of Birth	ADDRESS	AMOUNT OF INCOME	VERIFIED

DO YOU OR DOES ANYONE IN YOUR HOUSEHOLD RECEIVE ANY OF THE FOLLOWING? PLEASE CHECK ALL ITEMS.

	YES	NO	AMOUNT
FINANCIAL ASSISTANCE FROM DSS (AFDC, GEN. DISABILITYASSISST., GEN. ASSISTANCE FOR INELIGIBLE SPOUSE, OPTIONAL OR MANDATORY SUPPLEMENT)			
SUPPLEMENTAL SECURITY INCOME (SSI)			
SOCIAL SECURITY INCOME			
VETERANS ADMINISTRATION BENEFITS (VA)			
OTHER PENSION AND RETIREMENT INCOME, RAILROAD RETIREMENT			
WORKMAN'S COMP./UNEMPLOYMENT COMP., STRIKE BENEFITS			
TRAINING STIPEND (BOARD, FOOD)			
CHILD SUPPORT AND ALIMONY			
MONEY FROM RELATIVES OR FRIENDS			
INTEREST, DIVIDENDS, OR TRUST INCOME			
OTHER (SPECIFY)			
PAYMENTS FROM INSURANCE CO.			
PAYMENTS FROM BOARDERS/RENTERS			

NUMBER OF FAMILY MEMBERS______________ APPLICANT'S ESTIMATED INCOME____________________________
VERIFIED INCOME___________________________________ ALLOWABLE CREDIT______________________________
UPDATE INTERVAL___________________________________
NOTES:____

I HEREBY AUTHORIZE CAROLINA HEALTH CENTERS TO VERIFY ALL OF THE INFORMATION GIVEN ABOVE. I UNDERSTAND THAT IF THERE IS ANY INCORRECT OR MISLEADING INFORMATION I WILL BE TERMINATED FROM THE DISCOUNT PROGRAM AND WILL BE REQUIRED TO PAY FULL FEES.

I AGREE TO PROVIDE DOCUMENTATION AS PROOF OF MY ELIGIBILITY WITHIN 7 DAYS. BY FAILING TO DO SO, I WILL BE RESPONSIBLE FOR THE FULL FEE. I UNDERSTAND THAT THIS DISCOUNT EXPIRES ONE YEAR FROM TODAY AND THAT I MUST REAPPLY IN ONE YEAR TO CONTINUE TO RECEIVE THIS DISCOUNT.

Signature of Patient   Signature of Interviewer   Date