NAME: ____ DOB: ____________________

PATIENT INFORMATION	GUARANTOR INFORMATION
Name:	Name:
Address:	Address:
DOB:	DOB:
Sex:	Phone:
SSN:	Email:
Email:	Relationship:
Home:	PRIMARY INSURANCE INFORMATION
Mobile:	INS CO:
Work:	Policy holder name:
Contact preference: home/mobile/work/portal/mail	Policy holder DOB:
Language:	Policy holder sex:
Race:	Relationship:
Ethnicity:	SECONDARY INSURANCE INFORMATION
Marital status:	INS CO:
EMERGENCY CONTACT	Policy holder name:
Name:	Policy holder DOB:
Phone:	Policy holder sex:
Relationship:	Relationship:
PHARMACY INFORMATION	EMPLOYER INFORMATION
Pharmacy:	Employer:
Phone:	Phone:
Address/cross street:	
HOW DID YOU HEAR ABOUT US? *(circle one)* Friend Family Drove By Yellow Pages Another Physician Other	

To the best of my knowledge the above information is complete and accurate. By signing below, I give permission for Sensenbrenner Primary Care to access my pharmacy benefits data electronically. This consent will enable Sensenbrenner Primary Care to determine the pharmacy benefits and drug coverage information and download an historic list of all medications prescribed by any provider. I hereby authorize payment of medical benefits to Sensenbrenner Primary Care for services rendered and this authorization shall remain for any service(s) provided. I understand that I am financially responsible for medically unnecessary and non-covered services. I authorize my provider's office to contact me by mobile phone.

____

Printed Name of Patient Signature of Patient or Personal Representative

____

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

NAME: ____ DOB: ____________________

ASSIGNMENT OF BENEFITS and POLICIES

Phone and Text Message Communications: I authorize Sensenbrenner Primary Care and its representatives (including third-party agents) to contact me by phone using pre-recorded messages and/or automated dialing systems at any phone number associated with me or my personal representatives, including wireless numbers, in connection with any matter relating to my treatment, payment, or account, or to advise me of products or services that may be of interest to me. I can only decline to receive further calls or messages by following the reasonable instructions specifically provided by Sensenbrenner Primary Care. I understand that I am not required to agree to receive phone calls and messages in order to receive treatment or other Sensenbrenner Primary Care services. By providing my email address and cell phone number, I give permission for Sensenbrenner Primary Care (including its agents and contractors) to send me information, reminders, and messages using those means of communication. I authorize Sensenbrenner Primary Care to send me unencrypted messages using these means of communication, and I understand and accept the risks associated with doing so.

Authorization for Treatment: I, whether signed as the patient, the personal representative of the patient, or the patient's legal guardian, hereby consent to and grant permission for the examination, testing, and treatment of patient by Sensenbrenner Primary Care.

On Call Service: Sensenbrenner Primary Care offers an on-call service for its patients the days and evenings the office is closed. This service is for established patients and is to be used for serious medical concerns only. The on-call service WILL NOT do the following: refill medications, phone in narcotic medications, or answer non-critical medical questions (i.e., check on referrals, discuss test results or medical conditions). Persons who abuse the on-call service with non-clinical inquiries may be subject to a charge.

Missed Appointments: If you cannot keep your appointment, you must cancel 24 hours prior to your scheduled appointment. As a courtesy, we will attempt to contact you two business days prior to your appointment to remind you. However, it is ultimately your responsibility to keep up with your appointments. Missed appointments or appointments canceled with less than 24 hours' notice will incur a $50.00 fee. You may be dismissed from the practice for excessive no-shows or cancels with less than 24 hours' notice.

Wellness Visits: Please be aware that most insurance plans will cover preventive wellness services, including your annual wellness visit, once "per year". A year can be defined as a benefit period, calendar year (Jan-Dec) or 365 days. Please contact your insurer to understand your eligibility for preventive wellness services as services received prior to your eligible date will be denied and the charges will be your responsibility.

Forms, Letters, Handicapped Tags: You may require forms or letters to be completed by a provider. Completion of forms requires administrative time to gather data, physician time to review and time to complete the form. We have an established form completion policy. *We are not obligated to complete these forms. We reserve the right to refuse to complete any form. If records are requested, in addition to a completed form, then the form will be sent from our office once payment has been received from the company requesting this information. No forms or records will be sent to a third party without a signed release from the patient.*

• You must be an established patient; we cannot complete forms until you have been seen in our office at least 3 times.
• Forms cannot be completed on the day presented to the office unless you have scheduled an office visit specifically for forms completion. When you schedule your appointment, inform the scheduler that you have forms.
• Blank forms will not be accepted. Personal information needs to be completed.
• Forms are completed for those accounts in good standing. Outstanding balances need to be paid prior to forms being filled out.
• Many forms require a current examination prior to being completed. If this is the case, you will be notified and asked to schedule an office visit. You will not be charged for both the office visit and the form completion. Please understand that your insurance may not cover an office visit for form completion and if they do not, the charge is your responsibility.
• If you have seen a provider within the past 3 months, then you may leave the forms and a provider will complete them and return them to you.
• All forms and letters require seven (7) business days to complete.
• Fees for letters requested on SPC letterhead for medical necessity (including but not limited to): • Jury duty: $25 • All other letters requested based on content: $50-$100
• Fees for form completion (including, but not limited to, disability, FMLA, DMV, FL2, DME, biometric screening, insurance review, etc.): • 1 page: $25 • 2-5 pages: $35 • 6-10 pages: $50 • 10+ pages: $100
• Fees for handicapped tags/parking permits: $25 (Please note SPC will consider a handicapped tag ONLY if the patient is wheelchair bound, on crutches or a walker or is on continuous oxygen therapy)

Portal: To enroll in patient portal, just give us your email and we'll send you the link to complete your enrollment. You can view lab results, allergies, medications, past medical history, vitals, appointments, request refills. Visit our website www.sensenbrennerprimarycare.com to find the link to the portal or to visit the portal directly visit https://20425.portal.athenahealth.com/.

(Please note: Prescription refills should be requested through your pharmacy. Never use messages for time sensitive communication or emergencies. The healthcare providers may only have time to check their messages at the end or beginning of a busy day. Expect at least 48 hours before receiving a response. Messages left on Fridays may not be answered until Monday afternoon. Please respect the limited time that providers have to respond to the many messages they receive each day. Medical questions requiring complex medical

decision making may be subject to a charge. We reserve the right to limit the quantity of messages sent.)
In-Network Insurance: Sensenbrenner Primary Care will file claims for in-network insurances. You are responsible for knowing your health insurance benefits, including deductibles, co-payments, coinsurance and if there are any exclusions to your policy. You are responsible for assuring that all referrals and/or authorizations are obtained for each visit. You will be expected to present a current copy of your insurance card(s) on every visit. For successful claim filing it is necessary that you provide us with accurate and current insurance and demographic information, an assignment of benefits and an authorization to release information. You certify that all information given is correct to the best of your knowledge and any changes to your information will be reported to Sensenbrenner Primary Care as soon as it is known by you. If you have insurance with a company or government agency with which we are contracted, any co-payments, co-insurance or deductibles required by your insurance company must be paid at the time of service. If you are unable to make your co-payment at the time of your scheduled appointment you may be asked to reschedule your appointment.
Out of Network Insurance: If Sensenbrenner Primary Care is not contracted with your insurance company, payment in full for services rendered is due at the time of service. We will courtesy file a claim on your behalf and they will reimburse you directly.
Self-Pay (No Insurance): A patient that does not have third party coverage from a health insurer, health care service plan, Medicare, or Medicaid and does not have an injury that is compensable for the purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by SPC is eligible for a discount under our Uninsured Self-Pay Prompt Payment Discount Policy. It does not apply to patients classified as underinsured (i.e., patients who present insurance coverage that is limited or otherwise does not adequately cover the patient's charges) or patients who have health insurance whose out of pocket responsibility is derived from a non-covered service, co-pay, coinsurance, or deductible. A $50.00 uninsured self-pay pre-payment is made prior to or during appointment check-in (pre-payment applied to balance at check-out). *Payment in full must be received on the date of service during check-out*. SPC reserves the right to reverse the discount if a) a potential payer source is identified, b) the patient fails to pay in full at the time of service during check-out, c) the patient's payment by check is returned by the bank (NSF check). Services provided by outside vendors (e.g., outside lab services) are not covered by this policy and questions related to discounts should be referred to the vendor directly.
Accident or Personal Injury: If you are being treated due to a personal injury lawsuit or a motor vehicle accident, payment will be your responsibility at the time of service.
Worker's Compensation: Please contact your employer for a list of approved providers. We are not a workers compensation provider.
Balances on Accounts: You understand and agree that ultimately you are responsible for any balance on your account, regardless of insurance status, and that non-payment of your account may result in the account being subject to collection agency or legal action. We will send you a statement monthly for any balance due on your account. Any patient who owes a balance on his or her account must be prepared to pay the balance due upon arrival at his or her next appointment. Failure to do so can result in cancellation of the scheduled appointment. If you are unable to pay the balance in full, you need to contact the office as soon as possible to make arrangements. Unless other arrangements are made with us in writing, the balance on your statement is due and payable when the statement is issued and is past due if not paid within thirty (30) days. If your account becomes past due, we will take the necessary steps to collect the debt up to and including legal action. If we must refer your account to an outside collection agency, small claims court or an attorney you agree to pay all costs associated with the legal collection of the debt. Failure to pay your account or to make satisfactory payment arrangements with us may result in termination of the physician-patient relationship with you. Once an account is transferred to collections, statement activity will cease. You will need to call the office to pay a collections balance.
Returned Checks: Sensenbrenner Primary Care will charge $25.00 for any returned checks. Payment in full (amount of check + $25.00 fee) is due ten (10) days after we contact you regarding the check. Payment on returned checks must be paid with cash, Visa, or MasterCard only. We will not accept a check to cover the returned check. Repeat offenders will not be permitted to pay with checks. We also reserve the right to dismiss repeat offenders from the practice.
Release of Billing Information: I, whether signed as the patient, the personal representative of the patient, or the patient's legal guardian, understand that Sensenbrenner Primary Care can use my information for treatment, payment, and health care operations, as further outlined in the Sensenbrenner Primary Care Notice of Privacy Practices. I hereby authorize Sensenbrenner Primary Care to disclose by voice, fax, electronic or written methods, all or any part of patient's medical information as necessary for treatment and to process insurance claims on my behalf.
Medication History Authority: Formulary Benefits Data</u>: Formulary benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBMs are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain drug formularies, which are lists of dispensable drugs covered by a particular drug benefit plan. Sensenbrenner Primary Care will access my pharmacy benefits data electronically through RxHub. This allows us to: 1) Determine the pharmacy benefits and drug co-pays for a patient's health plan 2) Check whether a prescribed medication is covered (in formulary) under a patient's plan 3) Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications 4) Determine if a patient's health plan allows electronic prescribing to mail order pharmacies, and if so, e-prescribe to these pharmacies 5) Download an historic list of all medications prescribed for a patient by any provider.

NAME: ____ DOB: ____________________

Assignment of Benefits: I, whether signed as the patient, the personal representative of the patient, or the patient's legal guardian, hereby assign to Sensenbrenner Primary Care, all insurance benefits to which patient may be entitled by virtue of insurance or public funding for services provided by Sensenbrenner Primary Care on behalf of patient. In addition, I authorize Sensenbrenner Primary Care to file claims for all services rendered by Sensenbrenner Primary Care on behalf of patient. I hereby assign payment of benefits to Sensenbrenner Primary Care, for any and all services rendered, and claims filed by Sensenbrenner Primary Care. This authorization is valid from the date signed until written notice of cancellation is received or a new authorization is signed. I understand that I am responsible for any and all charges not covered or paid by this assignment. In addition, I/we further warrant and represent that any insurance which I/we assign is valid insurance and in effect and that I/we have the right to make this assignment. I understand that I am financially responsible to Sensenbrenner Primary Care for amounts due that are not covered by this assignment. Non-payment of your claim by your insurance company does not relieve you of financial responsibility for the remaining balance. For example, I know that sometimes insurance companies will not pay for services ordered by my providers and which I have authorized. I understand that these payment denials occur for a variety of reasons. My insurance policy may not include the particular service as a benefit. In other cases, a service will not be covered by my insurance company because it decides the service is not necessary, despite my provider's decision to order the service. In any event, even if a service is not covered by insurance, I agree to pay for all charges for all services rendered, including the specific services rendered as part of medical treatment. If Sensenbrenner Primary Care deems necessary, I authorize Sensenbrenner Primary Care to file member grievances on my behalf with my health plan for any denied claims. I appoint representatives of Sensenbrenner Primary Care to act as my representative in pursuing such grievances. I further agree that in the event benefits paid under this assignment or any other amounts paid by me/us or on my/our behalf exceed the amounts due Sensenbrenner Primary Care, my providers, or those professional groups or entities for services in connection with this medical treatment, any such excess amount may be applied to any other indebtedness that I or my spouse or any child for whom I am financially responsible may have to Sensenbrenner Primary Care or any other facility or entity related to Sensenbrenner Primary Care, my providers, or other professional groups or entities included in this assignment.

I have read and understand the information described in "POLICIES AND INFORMATION"

____

Printed Name of Patient Signature of Patient or Personal Representative

____

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

NAME: ____ DOB: ___________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been provided with a copy of Sensenbrenner Primary Care's Notice of Privacy Practices.
I know that the Notice may be changed at any time.
I may get a new copy of the Notice on Sensenbrenner Primary Care's website at www.sensenbrennerprimarycare.com; by writing to the Privacy Official, Sensenbrenner Primary Care 8821 Blakeney Professional Dr. Charlotte, NC 28277; or by asking for a copy at Sensenbrenner Primary Care.

Printed Name of Patient	Signature of Patient or Personal Representative
Date	Description of Personal Representative's Authority (attach documentation)

FOR OFFICE USE ONLY

- ❑ We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because
- ❑ An emergency existed and a signature was not possible at the time.
- ❑ Patient refused to sign. Patient was informed that signing merely acknowledges that the Notice has been made available to the patient.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason: ____

Signature of staff member	Date

NAME: ____ DOB: ____________________

AUTHORIZATION FOR RELEASE OF INFORMATION – COMPOUND RELEASE

Name of Patient ____ Date of Birth ___________ __________________

SENSENBRENNER PRIMARY CARE is authorized to release protected health information about the above-named patient in the following manner and/or to the selected person(s).

Check each person/entity approved to receive information.	Check type of information 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[1] ____ [1]For email communication to occur, please accept the disclosure below:	❑ Financial ❑ Medical ❑ Appointment reminders ❑ Breach notification
❑ Text communication – Provide number[1] ____ [1]For text communication to occur, accept the disclosure below:	❑ Appointment reminder ❑ Other: _________________________________
[1]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 by contacting our office.
- 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 may 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.

____

Printed Name of Patient | Signature of Patient or Personal Representative

____

Date | Description of Personal Representative's Authority (attach documentation)

NAME: ______________________________ DOB: ____________________

HEALTH HISTORY

PREFERRED LAB	
PREFERRED IMAGING FACILITY	
OTHER SPECIALTY DOCTORS YOU SEE (*Please include doctor name, location, phone # and specialty)*	
ALLERGIES *(what and reaction)*	
MEDICATIONS *(drug/dose/frequency)*	

VACCINATIONS *(most recent date)*		
FLU	Pneumonia	Tdap
Hepatitis A	Hepatitis B	Shingles
HPV9	Meningococcus	

PAST MEDICAL HISTORY	
❑ ADD/ADHD	❑ HIV/AIDS
❑ Anemia	❑ Anxiety disorder
❑ Arthritis	❑ Asthma
❑ Blood clots (DVT, PE)	❑ Blood disease
❑ Cancer (specify)	❑ COPD
❑ CHF (congestive heart failure)	❑ CAD (coronary artery disease)
❑ Depression	❑ Diabetes
❑ Gout	❑ Heart disease/arrythmia
❑ Hepatitis	❑ High cholesterol
❑ Hypertension	❑ Hyperthyroid
❑ Hypothyroid	❑ Kidney disease (stage ___________)
❑ Liver disease	❑ Osteoporosis
❑ Reflux/GERD	❑ Seizure disorder
❑ Other (specify)	

FAMILY HISTORY			
❑ Alzheimer's/Dementia	mother father sibling	❑ Depression	mother father sibling
❑ Anxiety disorder	mother father sibling	❑ Diabetes	mother father sibling
❑ Arthritis	mother father sibling	❑ Heart disease/arrythmia	mother father sibling
❑ Asthma	mother father sibling	❑ High cholesterol	mother father sibling
❑ CAD (coronary artery disease)	mother father sibling	❑ Hypertension	mother father sibling
❑ Cancer (specify)	mother father sibling	❑ MI (heart attack)	mother father sibling
❑ COPD	mother father sibling	❑ Migraine	mother father sibling
❑ CVA (stroke)	mother father sibling		
❑ Other (specify)			

NAME: ____ DOB: ____________________

SURGICAL HISTORY and PREVENTIVE SCREENINGS *(most recent date)*		
Colonoscopy	Diabetic eye exam	
Hysterectomy *(partial / total)*	Mastectomy *(right / left / bilateral)*	Hysterectomy *(partial / total)*
Amputation	Angioplasty	Amputation
Bariatric surgery	Bypass	Bariatric surgery
Cancer surgery *(specify)*	ENT surgery	
Eye surgery	Gallbladder surgery	Hernia repair
Joint replacement	Neurosurgery *(neck, back, other)*	Orthopedic surgery
Thyroidectomy	Tonsillectomy	Total colectomy
Other (specify)		

GYNECOLOGICAL HISTORY *(women only)*	
Date of last pap smear	History of abnormal pap? ❑ YES ❑ NO
Date of LMP	If menopausal, age at menopause
# of pregnancies	# of births
Date of last mammogram	History of abnormal mammogram? ❑ YES ❑ NO
Date of last bone density	History of abnormal bone density? ❑ YES ❑ NO

SOCIAL HISTORY

TOBACCO USE

❑ Never smoker ❑ Former smoker ❑ Current daily smoker ❑ Current some days smoker

If you smoke, how many packs per day? __________ What age did you start smoking? __________

Do you use smokeless or chewing tobacco? YES / NO If yes, what kind? ____________ How often? ____________

ALCOHOL INTAKE ❑ None ❑ Daily ❑ Weekly ❑ Monthly

How many drinks? __________

How many days in the past year have you had a heavy drinking consumption (4+ female, 5+ male)? _______________

CAFFEINE INTAKE ❑ None ❑ Occasional ❑ Moderate ❑ Heavy

GENERAL STRESS LEVEL ❑ Low ❑ Medium ❑ High

OCCUPATION	# OF CHILDREN	
Illicit drug use	❑ YES	❑ NO
Are you ambulatory?	❑ YES	❑ NO
Able to care for self	❑ YES	❑ NO
Live alone or with others	❑ ALONE	❑ WITH OTHERS
Hard of hearing in one or both ears	❑ YES	❑ NO
Legally blind in one or both eyes	❑ YES	❑ NO
Currently employed	❑ YES	❑ NO
Guns present in home	❑ YES	❑ NO
Smoke alarm in home	❑ YES	❑ NO
Sunscreen used regularly	❑ YES	❑ NO
Seat belts used routinely	❑ YES	❑ NO

NAME: ______________________________ DOB: ____________________

PATIENT HEALTH QUESTIONNAIRES	
Over the last 2 weeks, how often have you been bothered by any of the following problems?	0=not at all 1=several days 2=more than half of days 3=nearly every day
Little interest or pleasure in doing things	❑ 0 ❑ 1 ❑ 2 ❑ 3
Feeling down, depressed, or hopeless	❑ 0 ❑ 1 ❑ 2 ❑ 3
--- STOP! ONLY CONTINUE IF YOU SCORE 4 OR MORE ON THE FIRST 2 QUESTIONS ---	
Trouble falling or staying asleep, or sleeping too much	❑ 0 ❑ 1 ❑ 2 ❑ 3
Feeling tired or having little energy	❑ 0 ❑ 1 ❑ 2 ❑ 3
Poor appetite or overeating	❑ 0 ❑ 1 ❑ 2 ❑ 3
Feeling bad about yourself- or that you are a failure or have let yourself or your family down	❑ 0 ❑ 1 ❑ 2 ❑ 3
Trouble concentrating on things, such as reading the newspaper or watching television	❑ 0 ❑ 1 ❑ 2 ❑ 3
Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot	❑ 0 ❑ 1 ❑ 2 ❑ 3
Thoughts that you would be better off dead or of hurting yourself in some way	❑ 0 ❑ 1 ❑ 2 ❑ 3
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? ❑ Not difficult at all ❑ Somewhat difficult ❑ Very difficult ❑ Extremely difficult	

PATIENTS OVER AGE 65 ONLY		
Do you have an advance directive?	❑ YES	❑ NO
Do you have a medical power of attorney?	❑ YES	❑ NO
Have you fallen in the past year?	❑ YES (2)	❑ NO (0)
Do you use or have you been advised to use a cane or walker to get around safely?	❑ YES (2)	❑ NO (0)
Do you sometimes feel unsteady while walking?	❑ YES (1)	❑ NO (0)
Do you steady yourself by holding onto furniture when walking at home?	❑ YES (1)	❑ NO (0)
Do you worry about falling?	❑ YES (1)	❑ NO (0)
Do you need to push with your hands to stand up from a chair?	❑ YES (1)	❑ NO (0)
Do you have trouble stepping up onto a curb?	❑ YES (1)	❑ NO (0)
Do you often have to rush to the toilet?	❑ YES (1)	❑ NO (0)
Have you lost some feeling in your feet?	❑ YES (1)	❑ NO (0)
Do you take medicine that sometimes makes you light-headed or more tired than usual?	❑ YES (1)	❑ NO (0)
Do you take medicine to help you sleep or improve your mood?	❑ YES (1)	❑ NO (0)