NOVANT HEALTH

Outpatient Information / Consent to Treat

PATIENT INFORMATION	Account #:	Medical Record #:	Date:
Patient name:		Referring doctor:	Referring doctor phone #:
Address:		Primary doctor:	
City/State/Zip:		Employer/School:	
(H) Phone #: Cell phone:	Work phone:	Email address:	
Social Security #:	Date of birth:	Age: / Marital status:	Sex:
Race:	Ethnicity:	Religion:	
Emergency contact (name):	Relationship:	(H) Phone #: (C)	
Responsible party:	Relationship:	DOB:	SS#:
Responsible party address:	City/State/Zip:	Phone #:	

INSURANCE INFORMATION			
Primary Insurance:	Employer:	Secondary Insurance:	Employer:
Insurance ID #:	Insurance Group #:	Insurance ID #:	Insurance Group #:
Insured Name:		Insured Name:	
Address:		Address:	
City/State/Zip:		City/State/Zip:	
Insured DOB:	Insured Social Security #:	Insured DOB:	Insured Social Security #:

General Consent: I consent to medical care at Novant Health. This includes needed lab work and HIV testing. By law, I understand that if there is an at-risk exposure to my blood or body fluids, I may be tested for HIV, Hepatitis B or C virus. Those test results will be shared with the healthcare worker who was exposed. I am aware that healthcare is not an exact science. No guarantees have been made. If I am hospitalized, I agree to send any valuables home. I agree that Novant Health is not responsible for any loss or damage to my property.

I understand and agree with the above information. This consent is valid for three (3) years.

Patient or Responsible Person Signature: _____ ***Date*** _____ **Time** _____

Financial Responsibility: I agree to pay for <u>all</u> medical services provided. I understand that I may need to call my insurance company to see if they will approve and pay for the medical care. I am aware that the doctors and others providing care may not be employees of Novant Health. They are acting on their own and not at the direction of Novant Health. I understand I will receive a separate bill for their services. Please bill my health insurance plan as a service to me. I am aware that this does not mean that they will agree to pay for any services. I agree to pay whatever amount is not covered. Please apply for any health insurance coverage that may be available to me. I agree to help in this process. I assign all of my rights and claims for payment under any health insurance plan to Novant Health and any other treating providers. I appoint Novant Health, the other treating providers and/or their agents as my "authorized representative" to act for me in getting payment for services provided. If I pay more than what I owe for this medical visit, I agree that it can be used to pay for <u>any</u> unpaid bills I have with any Novant Health facility. I give permission to be contacted for treatment or payment purposes via any of the telephone numbers or email addresses I have given. This includes contact with a pre-recorded message, automatic dialing system, artificial voice, email message, or text message. Contact may also be made by businesses helping my providers collect money that I owe.

I understand and agree with the above information. This consent is valid for three (3) years.

Patient or Responsible Person Signature: _____ ***Date*** _____ **Time** _____

*** For delivering mothers, all of these responsibilities apply to your newborn baby.**

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted _____ ☐ Interpreter Refused

(Name/Number of Person/Services Chosen/Used)

Thank you for allowing us to participate in your healthcare! Please take a few moments to complete this form. Your healthcare provider will review this information during your visit. Filling out all sections will help us to better serve your health care needs.

Patient's Name: _____ **Date of Birth:** _____ **Chart/Acct #** _____

Preferred language spoken? ☐ English ☐ Spanish ☐ Other _____ Last grade of education completed _____

Are there any issues that may interfere with your appointments or medical care? ☐ Cost ☐ Memory ☐ Transportation

How can your healthcare provider best assist with your learning needs relative to your care?
☐ Audio/Video ☐ Written Material ☐ Discussion with your healthcare provider or nurse

☐ Yes ☐ No Do you depend on people living with you for personal care? If yes, what type of care? (Ex: bathing, dressing, mobility, etc.) _____

☐ Yes ☐ No Have you fallen in the last 12 months or do you have concerns regarding falls or home safety? If yes, please explain: _____

☐ Yes ☐ No Are there any cultural or religious beliefs that your health care provider should be aware of that would be helpful in your health care? If yes, please explain: _____

☐ Yes ☐ No Do you have any nutritional restrictions, needs or concerns? If yes, please list them: _____

☐ Yes ☐ No Have you been treated for pain in the past six (6) months to one (1) year? If yes, please explain what pain you were treated for (such as headache, back pain, etc.). _____
Which method seems to work the best for your pain? _____

☐ Yes ☐ No Do you have any history of mental, emotional, behavioral problems or depression?
If yes, explain briefly: _____

☐ Yes ☐ No Would you like information on advance directives? If you have an advanced directive (Living Will, Healthcare Power of Attorney, Advanced Instruction for Mental Health Treatment, Organ Donor Card), please provide a copy to be placed in your medical record.

☐ Yes ☐ No Have you been hit, kicked, punched or otherwise hurt by someone within the past year?
If so, by whom? _____

☐ Yes ☐ No Do you have concerns about your safety in your current relationship/environment?

☐ Yes ☐ No Is there a partner from a previous relationship who is making you feel unsafe now?

Patient Signature: _____ Date: _____ Time: _____

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(Name/Number of Person/Services Chosen/Used)

To be reviewed by provider once a year or when changes occur

Reviewed by: _____ Initials / Date _____ _____ Initials / Date _____

Reviewed by: _____ Initials / Date _____ _____ Initials / Date _____

Reviewed by: _____ Initials / Date _____ _____ Initials / Date _____

NOVANT HEALTH

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

Reason For Visit: _____

Preferred Pharmacy: _____

Present Medications: (If more space is needed please continue on back side of this paper.)

Medication Name	Strength	Directions
****If you are on oxygen, aspirn or any over the counter medication, please list it below******		
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

ALLERGIES:

- **Medication/Food:**_____ **Reaction:**_____
- **Medication/Food:**_____ **Reaction:**_____
- **Medication/Food:**_____ **Reaction:**_____

OB/GYN Status: FEMALES ONLY

Last Menstrual Period: _____ **Date of Last Mammogram:** ___/___/_____

____# of pregnancies ____ # of abortions____ # of miscarriages ____ # live of children

Breastfeeding? ___Yes ___No **Hysterectomy?** ___Yes ___No

Social History:

____Single ____Married ___Widowed ____Divorced ____Separated

Who do you live with? (name & relationship) _____

_____

Employed?: ___Yes ___No **Occupation:** _____

Do you have a living will? ____Yes ____No

Sexual History: ___Never had sex ___ Have sex with: ___Men ___Women ___Both

Drug/Alcohol/Tobacco Use:

Have you ever smoked? ____Yes___No **How many packs/day?**___ **How many Years?**___

Quit? ___Yes ___No **When?** ___/___/_____

Do you use any smokeless tobacco? ___Yes ___No **Quit?** ___/___/_____

Do you drink alcohol? ___Yes ____No **How many times/week?** ____

Quit? ___Yes ___No **When?** ___/___/_____

Do you use any street drugs? ___Yes ___No **If so what?** _____

Have you had your pnemonia vaccine? ___Yes ___No **If so when?** _____

Surgical History:

Surgery	Date	Location
Cataract		
Lasik		
Tonsillectomy		
Hysterectomy		
Heart Surgery		
Colonoscopy		
Hernia Repair		
Gall Bladder		
Tubal Ligation		
Orthopedic		
C-Section		
Other:_____		

Self/Family History:

	SELF	Mother	Father	Sister	Brother	Maternal Grandfather	Maternal Grandmother	Paternal Grandfather	Paternal Grandmother	Maternal Aunt	Maternal Uncle	Paternal Aunt	Paternal Uncle	Daughter	Son
Alcoholism															
High Blood Pressure															
Cancer															
COPD															
Arthritis															
Diabetes															
High Cholesterol															
Asthma															
Thyroid Disease															
Stroke															
Heart Disease															
Depression															
Emphysema															
HIV/AIDS															
Kidney Disease															
Other:_____															

*Mother Living? ___Yes ___No Cause of Death?_____

*Father Living? ___Yes ___No Cause of Death?_____

NOVANT HEALTH

ADULT PREVENTATIVE HEALTH GUIDE

Primary Care Partners
10500 Ligon Mill Road, Suite 113
Wake Forest, NC 27587

nhprimarycarepartners.org

JOSEPH MICCHIA, DO
GINA MICCHIA, DO

In an attempt to provide the best possible care to our patients, we have developed this Preventative Health Guide for our adult patients. Please take a few minutes to review current preventative health recommendations for your age group. For people with chronic diseases like diabetes ("sugar") or hypertension ("high blood pressure"), some screening tests may be necessary more often than listed below. Also, if you have a family history of certain diseases, especially cancers, you may need screening earlier than listed on this sheet; please ask the doctor about your special situation.

CURRENT RECOMMENDATIONS FOR ADULTS AGE 19-49:

- History and Physical Examination yearly
- Cholesterol level (blood test) every 5 years if normal
- Tetanus vaccine every 10 years and consider Hepatitis B, Varicella & Influenza vaccines
- Meningitis vaccine for those entering college
- Females: Breast Exam and PAP smear yearly by doctor and self breast exam, monthly
- Females: Mammogram yearly beginning at age 40 (earlier if you have a family history of breast cancer)
- Females: Digital rectal exam and colonoscopy beginning at age 40 (or earlier) if you have a family history of colon cancer)
- Males: Testicular exam yearly by doctor and monthly self-testicular exam
- Males: Rectal exam, prostate exam, PSA blood test and/or colonoscopy beginning at age 40 (or earlier, if you have a family history of prostate or colon cancer, or if you are African-American

I have read the above recommendations and have been provided with a duplicate copy of this sheet.

Print Name _____ Signature _____ Date _____

CURRENT RECOMMENDATIONS FOR ADULTS AGE 50-64:

- History and Physical Examination yearly
- Cholesterol level (blood test) every 5 years if normal
- Digital rectal exam yearly with fecal occult blood test and colonoscopy every 5-10 years
- Females: Breast exam and PAP smear yearly by doctor and self breast exam monthly
- Males: Testicular exam, prostate exam, and PSA blood test yearly by doctor, and monthly self-testicular exam
- Consider aspirin therapy to reduce risk for heart attack and stroke
- Tetanus vaccine every 10 years and consider Hepatitis B, Varicella & Influenza vaccines

I have read the above recommendations and have been provided with a duplicate copy of this sheet.

Print Name _____ Signature _____ Date _____

CURRENT RECOMMENDATIONS FOR ADULTS 65 AND OLDER:

- Same as for aged 50-64 except,
- Pneumonia vaccine every 6-10 years and consider Hepatitis B and Influenza vaccine yearly

I have read the above recommendations and have been provided with a duplicate copy of this sheet.

Print Name _____ Signature _____ Date _____

Joseph M. Micchia, DO
Gina L. Micchia, DO

Acknowledgement of Receipt of Notice of Privacy Practices

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

HIPAA – Notice of Privacy Practices

- I have been provided with a copy of Novant Health's **Joint 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 Novant Health's website at www.novanthealth.org; by writing to the Privacy Official, Novant Health Privacy Office, P.O.Box 33549, Charlotte, NC 28233; or by asking for a copy at any Novant Health facility.

_____

Patient's Signature Date/Time

_____ _____

Signature of Authorized Person Date/Time Relationship to Patient

For staff use only:

☐ *Patient refused to sign. Patient was informed that signing merely acknowledges that the Notice has been made available to the patient; or* ☐ *Patient was initially treated for an emergency condition. The Notice was made available to the patient either after stabilization or upon transfer.*

*Signature of Staff:*_____ *Date:*_____ *Time:*_____

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted _____ ☐ Interpreter Refused

(Name/Number of Person/Services Chosen/Used)