Novant MEDICAL GROUP

# 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: | 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 this facility. This includes needed lab work and HIV testing. I am aware that healthcare is not an exact science. No promises have been made. By law, I understand that if there is an at-risk exposure to my 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.

**Financial Responsibility:** I agree to pay for all 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. 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. I appoint Novant Health 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 any unpaid bills I have with any Novant Health facility. I give permission to be called on any of the telephone numbers I have given. This includes calls with a pre-recorded message, automatic dialing system or artificial voice. Calls may be made by businesses helping Novant Health collect money that I owe.

**I understand and agree with the above information. This consent is valid for one (1) year.**

***Signature of Patient or Authorized Person:*** _____ ***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)

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

## Authorization to Disclose Protected Health or Billing Information

Patient Name: _____ Patient Address: _____

Nickname/Maiden Name/Alias: _____

Phone #: _____

Date of Birth: _____ Medical Record Number:

**I give permission to:**

_____
(Name of Person/Facility)

_____
(Address)

_____
(City, State, Zip)

_____ _____
(Phone number) (Fax Number)

**To share my health information with:**

Primary Care Partners at Ligon Mill
(Name of Person/Facility)

**10500 Ligon Mill Road**
(Address)

**Wake Forest, NC 27587**
(City, State, Zip)

**919-570-5705** **919-570-5710**
(Phone number) (Fax Number)

**Check information to be shared:**

- ☐ Name
- ☐ Address
- ☐ Phone Number
- ☐ Insurance
- ☐ Social Security #
- ☐ Entire Medical Record
- ☐ History & Physical
- ☐ Laboratory Report
- ☐ Radiology Report
- ☐ Radiology Images
- ☐ Consultation
- ☐ Physician Dictation
- ☐ Nurses Notes
- ☐ Surgery Report
- ☐ Medication Records
- ☐ Progress Notes
- ☐ Discharge Summary
- ☐ Test Results

**Important Notice: This is a full release, including drug, alcohol, psychiatric and sexually transmitted disease information unless listed here:** _____

Treatment Dates (must be a specific date or range of dates)

**Check reason to share health information:** ☐ My (patient) request ☐ Legal ☐ Workers' compensation ☐ Disability ☐ Treatment:

☐ Insurance Other (Describe) _____

**Share Information:** ☐ In Person ☐ Pick up ☐ Fax ☐ Mail ☐ Other (Describe) _____

1. By law, Novant Health ("Novant") cannot use or share my health information without my permission, except by ways listed in Novant's Notice of Privacy Practices.
2. I can cancel this permission at any time. I must cancel in writing and address it to the person or organization named above. I cannot cancel the sharing of information already given as a result of this permission.
3. I do not have to sign this form. Refusal will not change my ability to get treatment, payment for treatment or benefits.
4. Once information is sent, it may not be protected by law. Someone may be able to share my information with others without my permission.
5. I have read, understand and, upon my request, been given a copy of this form.
6. This is not for use for Marketing or Research.

**NOTICE: There may be a fee charged to make copies of my medical record.**

**My permission ends 90 days after the date I signed, unless a date or event is written here:** _____

_____ _____
**Patient/Patient Representative Signature** **Date**

**Legal Authority to sign for patient:** ☐ Healthcare agent ☐ Guardian ☐ Attorney in Fact ☐ Parent ☐ Next of Kin ☐ Administrator/Executor

**If you are signing this permission as the patient's guardian, healthcare agent, attorney in fact or the administrator/executor of the patient's estate, you must provide appropriate documentation of legal authority before records may be released.**

**Patient is:** ☐ Minor ☐ Disabled ☐ Deceased ☐ Incompetent ☐ Incapacitated

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

☐ Interpreter accepted _____ ☐ Interpreter refused
(Name/number of person/services chosen/used)

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

## Communicating with Family and Friends

- We may communicate your information with others who are involved in your care.
- We will only communicate when we believe that this would be helpful to you.
- We are not able to keep any earlier requests made on the "Permission to Communicate with Family and Friends" form that you may have completed in the past.

## Sharing through *Care Everywhere*

*Care Everywhere* is part of the new electronic medical record (EMR) we are using. It lets your doctors, nurses and non-Novant healthcare providers share information about you. If you get treated in other places, this lets those taking care of you get your health information quickly.

If you do not want your health information shared through *Care Everywhere*, you may ask that it NOT be available through *Care Everywhere*. The Practice Manager of your doctor's office or the Health Information Management department at the facility where you are being treated can help you with this. If you decide not to allow your health information to be shared through *Care Everywhere*, other healthcare providers will not be able to access health information about you through our EMR.

## 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)



Name / MR # / Label