Hodges Family Practice, Inc.

Chart#_____

Patient Name: (F) _____ (M) _____ (L) _____

DOB_____ SSN _____ Sex: M F Language_____

Mailing Address_____ Home Phone#_____ Race_____

_____ Cell Phone#_____ Ethnicity_____

Name of Employer_____ Work Phone#_____ Marital Status_____

Retired: Y N Student: Y N Email Address_____

Local Pharmacy_____ Mail Order Pharmacy_____

Responsible Party

Name_____ DOB_____ SSN_____ Phone#_____

Address_____ Relationship to Patient_____

_____

Emergency Contact

Name_____ Relationship to Patient_____ Phone#_____

Billing Information

Primary Insurance: _____ Policy # _____ Group #_____

Subscriber Name: _____ Subscriber DOB_____ Patients Relationship to Subscriber:
SELF SPOUSE CHILD OTHER

Secondary Insurance: _____ Policy # _____ Group #_____

Subscriber Name: _____ Subscriber DOB_____ Patients Relationship to Subscriber:
SELF SPOUSE CHILD OTHER

Tertiary Insurance: _____ Policy # _____ Group #_____

Subscriber Name: _____ Subscriber DOB_____ Patients Relationship to Subscriber:
SELF SPOUSE CHILD OTHER

Patient/Responsible Party Signature_____ Date_____

Medical History Questionnaire

Patient Name: _____ DOB: _____

What is your chief complaint? (Include any current symptoms)

Chronic Medical Problems

Please indicate each of your chronic medical problems by marking the appropriate box bellow:				
__High Blood Pressure	__Heart Disease	__Skin Disease	__Glaucoma	__Anxiety
__High Cholesterol	__Atrial Fibrillation	__Erectile Dysfunction	__Lung Disease	__Depression
__Diabetes	__Stroke	__Kidney Disease	__COPD	__Acid Reflux
__Hypothyroidism	__Gout	__Kidney Stones	__Asthma	__Cancer_____
__Hyperthyroidism	__Arthritis	__Anemia	__Emphysema	__Other

Family History

Please indicate which family member and at what age were they diagnosed if known:		
High Blood Pressure_____	Stroke_____	Anxiety_____
Cholesterol_____	Heart Disease_____	Depression_____
Diabetes_____	Bleeding Disorder_____	Kidney Disease_____
Glaucoma_____	Lung Disease_____	Other:_____

Allergies

Indicate if you are allergic to any medications, x-ray dyes, or other substances.
☐ No Known Drug Allergies -If yes, list names & Reactions _____ _____ _____ _____

Medications

Prescriptions, Over-the-Counter, Vitamins, Herbal Supplements, Etc.						
Medicine	**Dose**	**Frequency**		**Medicine**	**Dose**	**Frequency**

Prevention (check all that apply)

Tobacco Use: __No __Yes-How many packs? ___ __Daily __Occasional __Former (year quit____) __ Tobacco Exposure	**Alcohol Use:** __No __Yes __Occasional __Moderate __Heavy __Daily __Family History of Alcoholism	**Illicit Drug Use:** __No __Yes __Former __Family History

__Drink Coffee/Tea __Exposed to AIDS __Tested for AIDS __Organ Donor __Exercise __Living Will

Other History

Please supply all dates for any surgery, hospitalizations, and procedures: (Month/Year)

Surgery	**Date**	**Hospitalizations**(other than surgery)**:** _____	**Gynecology/Obstetric:**	**Immunizations:**
		Last Mammogram:_____	Last Pap Smear:_____	Tetanus:_____
		Last Colonoscopy:_____	Last Menstrual Period:_____	Hep B:_____
		Last Cholesterol Check:_____	How many Pregnancies:_____	Influenza:_____
		Last Prostate Test:_____	Births:_____	Pneumovax:_____
			Miscarriages:____	

Hodges Family Practice, Inc.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ **Date of Birth:** _____
Phone (H):_____ **Phone(C):**_____
Address: _____ **City/ State/ Zip**_____
Please Note: *Copy Fee May Be Charged For Medical Records*

Above listed patient authorizes the following healthcare facility to make record disclosure:

Hodges Family Practice, Inc. **Phone# :(336) 626-6696**
610 N Fayetteville St. # 202 **Fax #: (336) 626-1592**
Asheboro, NC 27203

Dates and Type of information to disclose:
□ **2** Years from last date seen
□ **Dates other:** _____
□ **Specific Information Requested:** _____

The Purpose of disclosure is:
□ **Change** of insurance or physician
□ Continuation of care (E.G. VA MED CTR)
□Referral ___Other

Restrictions: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This Information may be disclosed and used by the following individual or organization:

Release From: _____
Address: _____
City/ State/ Zip: _____ □ **Please mail records**
Office Phone: _____ **Office Fax:**_____ □ **Please Fax records**

I Understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date or event _____. If I fail to specify and expiration date, event or condition, this authorization will expire 1 year from date signed.**

I understand that authorizing the discloser of the health information. I can refuse this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any discloser of information carries with it potential for an unauthorized disclosure and the information may not be protected by federal confidential rules. If I have questions about discloser of my health information, I can contact the authorized individual or organization making discloser.

I have Read the above foregoing Authorization for Release of Information and do hereby acknowledge that if I am familiar with and fully understand the terms and condition of this authorization.

Signature: _____ **Date::**_____
Patient/parent / guardian or authorized Representative

Hodges Family Practice, Inc.

CONSENT TO MEDICAL SERVICE

Patient Name: _____ Account#_____
DOB: _____

Consent to Medical Service
The undersigned consents to the procedures which may be performed, including emergency treatment or services, and which may include but are not limited to laboratory procedures, medical treatment or procedures, services rendered to the patient and employee protection program.

Authorization to Release Medical Information
I authorize Hodges Family Practice, Inc. may disclose all or any part of the patient's record to any person, company, or corporation which is or may be liable under a contract to the practice or to the patient or at a family member or employer of the patient of all or part of the practice charge, including but not limited to hospital or medical services companies, workman's compensation, or welfare funds. The patient's records may be forwarded to the specialist physician or to another facility in the event of transfer.

Assignment of Benefits
Insurance is billed as a courtesy to the patient and is not and obligation. The undersigned authorizes, whether he/she signs as agent or as patient, direct payment of any insurance benefits otherwise payable to or on behalf of the undersigned for these outpatient services, including emergency services if rendered. It is agreed that payment to the practice, pursuant to this authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment and any applicable co-payments, co-insurances, or deductible amounts.

Financial Responsibility
In the event the patient was evaluated by a Physician at the practice and advised to go to another facility or Physician for further treatment and evaluation, the undersigned agrees that they are responsible for any applicable co-payments, co-insurance, or deductible amounts.

_____ _____

Patient/Legal Representative Signature **Date**

Hodges Family Practice, Inc.

Notice of Privacy Practices Acknowledgement

Patient Name: _____ **DOB: _____**

I was offered a copy of the Hodges Family Practice, Inc. Notice of Privacy Practices. I understand that Hodges Family Practice, Inc. has the right to change its Notice of privacy practices from time to time and that I may contact Hodges Family Practice, Inc. at any time to obtain a copy of Notice of Privacy Practices.

Patient/Legal Representative Signature: _____ Date:_____

Release of Information

Please list the family members or other persons, if any, whom we may inform about your medical condition and your diagnosis including Treatment, Financials, and/ or Medical Records.

Name	Relationship to Patient	Phone Number	Information
			__Diagnosis __Financials __Med. Records __Treatments
			__Diagnosis __Financials __Med. Records __Treatments
			__Diagnosis __Financials __Med. Records __Treatments

Can confidential messages be left on your answering machine? YES NO

Patient Signature:_____ Date:_____

HODGES FAMILY PRACTICE, INC.

Come Let Our Family Take Care of Yours

Beth G. Hodges, MD
Francisco M. Hodges, MD
Irma M. Santiago, MD
Kimberly Underkoffler, PA-C
David Herring, PA-C

Dear New Patient,

We would like to take a moment to personally welcome you to our practice. We are pleased that you have chosen Hodges Family Practice for your primary care. It is our responsibility to deliver the best care possible to you. As a family-run medical practice, we specialize in treating families, infants, and children to adults and seniors. As such, we maintain a comprehensive medical office equipped to address medical issues that each group is apt to face. From management of chronic diseases, such as diabetes, hypertension, and hyperlipidemia; to infant pediatrics and vaccinations, our office is well-fitted and staffed to provide excellent healthcare for every age group. Beth G. Hodges, MD. and Francisco M. MD, are board certified in Family Medicine and committed to fruitful, beneficial patient-physician relationship. We are a Certified Patient Centered Medical Home.

In order to make your first visit more effective, please notify your health insurance company in advance of your new primary care provider.

When you arrive for your first appointment, please bring the following with you:

- All of your health insurance cards (we will ask for them at every visit).
- Photo identification card (for minors we ask for parent photo identification).
- All medications you are currently taking, including vitamins and over the counter medications

Please call our office if you have any questions or need to reschedule your first appointment. We do require 24-hour notice if you are unable to keep a scheduled appointment. It is our policy that after 3 missed appointments we reserve the right to discharge you from our practice.
Thank you for choosing Hodges Family Practice for you your health care needs.

Sincerely,
The Providers and Staff of Hodges Family Practice

Hodges Family Practice Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.
8. Missed appointments. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.
Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**

HODGES FAMILY PRACTICE, INC.

Prescription Refill Policy

How do I get my prescription refilled?

If you require a refill of a current medication from your provider at Hodges Family Practice, simply call your pharmacy and they will contact us for the refill information. Or you can make prescription refill requests using your Patient Portal. **Calling your physician's nurse/assistant will only delay the process.**

If you are requesting an antibiotic, or a refill for an antibiotic, please contact your PCP. This should not be left on the refill line. In most cases an appointment will be needed. In most cases, if you require a prescription for a new medication, you will need to schedule an appointment with your physician by calling our office.

HOW TO MAKE A REQUEST THROUGH PATIENT PORTAL

You can make prescription refill requests through Patient Portal online. When you make a request, we will assess and complete the request if you are approved for a refill. Once we have completed the request, you will receive a message saying that your prescription has been filled and is available at your pharmacy. Sometimes prescriptions cannot be sent electronically to pharmacies. If this is the case, we will send you a message notifying you that your script is available for pick up.

PRESCRIPTION REFILL TIPS

- Remember that it takes 3-4 business days to process a prescription refill request
- Always try to make the request when you have about a 10-day supply left to ensure that you do not run out.
- If there are no more refills on the bottle, do not use that prescription number. When we send in a new prescription it will be assigned a new prescription number and it could be overlooked if the pharmacy is looking for the old prescription number
- At your scheduled appointment, please ask your provider to send refills on your chronic mediations to your pharmacy. This will eliminate your need to contact our office and ensure you are able to take all your medications as directed.
- Pain medications will not be automatically refilled; the refill of pain medications will be completed only at your office visit. Pain medications require a hand-written prescription. All patients prescribed pain medications should be aware of the office's policy on pain medications.

MAIL ORDER PHARMACY

Mail Order Pharmacies prescription refills can be sent electronically. In most cases, we are notified by the mail order pharmacy when the patient requires refills. Please call your mail order pharmacy when requesting refills. The pharmacy will contact the office which will eliminate a delay in receiving your medications. We do have the ability to send prescriptions electronically to some mail order pharmacies. This is only for regular maintenance medications. Please keep in mind that it takes 2-3 business days to process your prescription request. Contacting our office to check on the status of your refill will only delay this.

Prescription Refill Denials

Your refill request will be denied under the following circumstances:

- Lack of follow up appointment. The standards of care require all patients to be seen at certain intervals dependent on their medical conditions.
- Lack of lab work. Lab work is performed to ensure the medication your taking is working to your betterment. We are required to perform lab work for medication refills.
- All controlled substances require an office visit with your provider
- Antibiotics will never be filled without an office visit. This is for your safety

We appreciate your understanding of our policy. We designed the policy with your best interest in mind as well as your healthcare.

Thank You.

Hodges Family Practice, Inc.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ Date of Birth: _____
Phone (H):_____ Phone(C):_____
Address: _____ City/ State/ Zip_____

Please Note: *Copy Fee May Be Charged For Medical Records*

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Asheboro, NC 27203

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□ **2** Years from last date seen
□ **Dates other: _____**
□ **Specific Information Requested: _____**

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This Information may be disclosed and used by the following individual or organization:

Release From: _____
Address: _____
City/ State/ Zip: _____ □ **Please mail records**
Office Phone: _____ Office Fax:_____ □ **Please Fax records**

I Understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date or event _____. If I fail to specify and expiration date, event or condition, this authorization will expire 1 year from date signed.**

I understand that authorizing the discloser of the health information. I can refuse this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any discloser of information carries with it potential for an unauthorized disclosure and the information may not be protected by federal confidential rules. If I have questions about discloser of my health information, I can contact the authorized individual or organization making discloser.

I have Read the above foregoing Authorization for Release of Information and do hereby acknowledge that if I am familiar with and fully understand the terms and condition of this authorization.

Signature: _____ Date::_____
Patient/parent / guardian or authorized Representative

HODGES FAMILY PRACTICE, INC.

Patient Referrals Policy

At Hodges Family Practice, we field a lot of questions from patients and caregivers about referrals – why they're required, and how they work. A referral, in the most basic sense, is a written order from your primary care doctor to see a specialist for a specific medical service. Referrals are required by most health insurance companies to ensure that patients are seeing the correct providers for the correct problems. While this may seem to some like an extra, unnecessary step, failure to obtain the necessary referral before seeing a specialist can result in coverage not being applied to a visit or service, and costs being passed on directly to the patient. The referral process is complex, requiring actions from a variety of entities. Because of this, it's helpful to understand the considerations and steps that take place after your provider has decided that you would benefit from the expertise of a specialist.

The Steps That Take Place in the Referral Process:

Insurance

The first question we will ask you is whether or not we have your most recent insurance information on file. This is important because each plan has its own unique set of conditions for referrals. Once we have that information, we can assess if any authorizations are required to allow you to see the specialist. In addition, many insurance plans will only authorize consultations with contracted providers.

Submission

After it has been determined that an authorization is required, your provider's Medical Assistant will submit the appropriate forms and documentation to the insurer. The insurer will process them and return its own authorization or denial usually within 48-72 hours. Upon receipt, insurer approval and documentation will be forwarded to the specialist. Depending on the insurance company, this process can take up to 14 days.

Specialist Approval

Specialists often have a process of their own, where they screen referrals for appropriateness clinically. They also must verify that they contract with the insurance company. After this process is complete, they will contact you, the patient, directly to make an appointment.

It is always in your best interest if we have your updated contact information in our electronic record system because that is the information we send to the referring provider. If you have had a recent change of address or phone number, it can delay the referral process. An easy way to check your contact information is to visit your portal account online or to call our office.

Even if you are one of the fortunate ones who has an insurance plan that does not require authorization for specialty care, many specialists will not accept a consult without complete records. These include visit notes, lab and x-ray results. In general, the longer you have had a problem and the more in-depth the workup is, then the longer it can take to collect the data the specialist requires. This is important because you want your appointment with a specialist to be as productive as possible and not repeat tests that have already been done.

It is not uncommon for a specialist to review the case and ask for further tests to be done prior to the consultation. Unfortunately, these very tests may require authorization from your insurer to perform.

Things Patients Can Do

- If you are able to schedule an appointment with the specialist we referred you to, **it's important to make every effort to get to that appointment**. Most specialists will not re-appoint you if you have a "no show". For those who do miss their appointment, the process above must be repeated, and often options for specialists are more limited the second time around, and require more travel for the patient.
- If your provider has told you a referral will be made and you have not heard anything within at least **two weeks**, please call to check on the status of your referral. Because the process is complex, it can be subject to delays. Your patient care team can look into the referral for you and let you know where things stand. If you believe you are in need of a referral or wish to speak with your patient care team about an existing referral, please contact our office. (336)626-6696.

Thank you,
Your Patient Care Team

Hodges Family Practice, Inc.

Notice of Privacy Practices Acknowledgement

Patient Name: _____ DOB: _____

I was offered a copy of the Hodges Family Practice, Inc. Notice of Privacy Practices. I understand that Hodges Family Practice, Inc. has the right to change its Notice of privacy practices from time to time and that I may contact Hodges Family Practice, Inc. at any time to obtain a copy of Notice of Privacy Practices.

Patient/Legal Representative Signature: _____ Date:_____

Release of Information

Please list the family members or other persons, if any, whom we may inform about your medical condition and your diagnosis including Treatment, Financials, and/ or Medical Records.

Name	Relationship to Patient	Phone Number	Information
			__Diagnosis __Financials __Med. Records __Treatments
			__Diagnosis __Financials __Med. Records __Treatments
			__Diagnosis __Financials __Med. Records __Treatments

Can confidential messages be left on your answering machine? YES NO

Patient Signature:_____ Date:_____

Hodges Family Practice, INC.

NO SHOW AND CANCELLATION POLICY

Effective: 01/01/2021

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel, and we are unable to schedule you for a visit due to a seemingly full appointment book.

NO SHOWS

A no show fee of $25.00 will be charged for appointment that are booked and the patient fails to show up for the appointment without calling or rescheduling in advance according to the cancellation policy.

Our office attempts to confirm appointments 2 days in advance as a courtesy. However, the No Show fee will be applied if the patient fails to show up for their appointment regardless of whether the patient spoke to our office verbally to confirm the appointment. If there are three no show appointments during a 12-month period, the patient is subject to dismissal from Hodges Family Practice.

Any no show fees are applied to the patients account and are due at time of visit.

CANCELLATIONS

Cancellations and rescheduling of appointment are required to be done at least 24 hours in advance. Appointments that are cancelled/ rescheduled without a 24-hour notice will have a $25.00 late cancellation fee applied to their account that are due at time of visit.

X _____