NORTHERN MEDICAL GROUP
FAMILY MEDICINE
a department of Northern Hospital

PATIENT INFORMATION

Last Name | First Name | Middle Name | Birth Date

Address | City | State | Zipcode

Home phone | Cell phone | Email | ❑ I decline to provide my email

Who referred you to this office?

Gender ❑ Male ❑ Female | Race (optional) | Ethnicity | Preferred language

Social Security Number | Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Medicare Number | Preferred Pharmacy

Health Insurance Company | Insurance Number

Spouse's Name | Birth Date | Phone | Work Phone

How would you prefer to be contacted? ❑ Phone ❑ Cell phone ❑ Voice mail ❑ Email ❑ Mail

EMPLOYER INFORMATION (Adult)

Patient's Employer | Phone

Employer's Address | City | State | Zipcode

Spouse's Employer | Phone

Spouse's Employer's Address | City | State | Zipcode

GUARANTOR INFORMATION

Guarantor's Full Name | Patient's Relationship to Guarantor

Home phone | Cell phone | Work phone | Gender ❑ Male ❑ Female

Guarantor's Address | City | State | Zipcode

Guarantor's Birth Date | Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed

EMERGENCY CONTACT

Name of Person | Relationship

Address | City | State | Zipcode

Home phone | Work phone | Cell phone

PHONE NUMBERS:
Providing us with a wireless telephone number or a landline number gives us your permission to call that number.

MEDICARE AUTHORIZATION:
I designate and authorize Medicare payments directly to Northern Medical Group Family Medicine for any benefits payable for services rendered.

AUTHORIZATION TO RELEASE INFORMATION AND BENEFITS:
I hereby authorize Northern Medical Group Family Medicine to release any medical information to the insurance company (s) that I designate, and to their agents, to determine benefits or benefit related services. I authorize payment directly to Northern Medical Group Family Medicine for any benefits payable for services rendered. I understand that regardless of whether any insurance coverage is applicable, I am responsible for this account in full, including any copay amounts or deductibles due at the time of my visit.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:
I acknowledge that I have received a copy of Northern Medical Group Family Medicine (Northern Hospital of Surry County) Notice of Privacy Practices.

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY OR OTHER AUTHORIZED REPRESENTATIVES:
I authorize the release to or discussion of my protected health information to the following people:
Name(s)/Relationship(s): _____

CONSENT TO TREATMENT:
I authorize Northern Medical Group Family Medicine to treat me as a patient, and I authorize such care, treatments and/or diagnostic studies to be performed as are deemed necessary by my healthcare Provider.

_____ _____ _____
Signature of Patient or Patient's Representative & Relationship **Date** **Time**

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INFORMED CONSENT TO USE PATIENT PORTAL

Northern Medical Group Family Medicine is offering a secure, HIPAA compliance communication tool as a courtesy to our patients. It is an optional service, and we reserve the right to suspend, change or terminate at any time. We will alert you to any changes as promptly as possible. This form is intended to inform you of the facts and risks surrounding the use of the web portal. By signing below, you confirm that you have read, understand, and agree to comply with our procedures and guidelines for using the Patient Portal. You also agree not to hold Northern Medical Group Family Medicine or any of their employees liable for network infractions beyond their control. You will be able to:

Update your medical history, demographics, insurance, medications
Check/request appointments
Receive clinical/appointment reminders
Receive test results
Review your medical history
Ask questions about billing
Send non–urgent messages

PRIVACY AND SECURITY

The web portal or webpage has a secure tunnel connection with our clinic that uses encryption to keep unauthrized persons from being able to access and read your health information or your communications to us. To help ensure that the tunnel remains secure, we need to have your current (private) email address and be informed if it changes. Keep you portal user ID and password secure so only you, or someone authorized by you, can gain access to your information. If you believe someone has learned your password, immediately go to the portal site and change it.

Your email address is confidential and protected information. With our best efforts, we will protect this information as we use your medical, pharmaceutical and other personal information. We will never purposely share this information with any third party.

All access to our internal network and electronic medical records (EMR) is password protected. Our staff members are instructed to log off their workstations when not physically present. Additionally, in compliance with HIPAA regulations, our EMR automatically logs the user off after a period of inactivity.

IF THERE IS AN EMERGENCY, OR URGENT NEED FOR COMMUNICATION, CALL 911 OR OUR OFFICE AT 336–786–4133. We will respond to non–emergency messages within 3 business days. All communications are inclued in your medical record.

NORTHERN MEDICAL GROUP FAMILY MEDICINE WILL NOT DIAGNOSE OR MAKE MEDICAL DECISIONS USING EMAIL. IF YOU ARE ILL OR HAVE A PROBLEM, PLEASE CALL 786–4133.

Email Address (Please Print): _____

Patient Name (Please Print): _____ Date of Birth: _____

Signature of Patient: _____ Date: _____

Signature of Guardian (if patient is under 18) _____

280 North Pointe Blvd.
Mt. Airy, NC 27030
Fax: (336) 786–4338 Phone: (336) 786–4133

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Medical Weight Loss Program

Weight Loss Program Consent Form

I, _____ authorize Northern Medical Group−Family Medicine, DR/NP/PA and whomever they designate as their assistants, to help me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, a regular exercise program, and instructions in behavior modification techniques, and may involve the use of FDA approved appetite suppressant medications. Other treatment options may include Human Chorionic Gonadotropin (hCG) injections. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safety and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the product literature.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that obesity may be a chronic, life−long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

I have read and fully understand this consent form and I realize that I should not sign this form if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.

If you have questions regarding the risks or hazards of the proposed treatment, or any questions whatsoever, concerning the proposed treatment or other possible treatments, ask your provider now before signing this consent form.

Patient :_____ Date: _____

Witness:_____Date:_____Time: _____

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Medical Weight Loss Program Insurance Information

Part or this weight loss program may not be covered by any insurance program.

Medical insurance policies do not typically cover an all-inclusive and comprehensive weight management program and related expenses which may include weighing, individual dietary counseling, injections, some prescription medications, special classes, and the related services we are offering.

If you are covered by Medicare insurance, you must complete and sign a separate informed waiver (Advance Beneficiary Notice of Noncoverage) prior to participation in this weight management program.

Initial one of the following paragraphs:

Medical Weight Loss will bill your insurance, however we make no promises of payment. An insurance agreement is a contract between you and the insurance company; we cannot accept responsibility for collecting your individual insurance claim or negotiating a settlement on a disputed claim. You are responsible for knowing your insurance plan's terms, coverage and referral guidelines.

−Or−

_____ The self−pay (insurance not billed) cost of the weight loss service is $69.00 per visit for an established patient and $119.00 for the first visit for a new patient and if paid on the date of service. If additional services are provided; or other diseases are treated, charges may be additional. Medications will be billed at the pharmacy of your choice, not through Medical Weight Loss. We will not retroactively bill your insurance.

By signing below, you are accepting responsibility for the services provided.

"I am aware that the services I am about to receive may not be covered by my health insurance plan(s). I was given an opportunity to ask about the cost of these services. By signing below, I am agreeing, in advance, to accept full financial responsibility for all costs associated with such non−covered services."

Patient Signature:_____Date: _____

Pharmacy and Prescription Information

I understand some prescription medications associated with the Medical Weight Loss Program may be prescribed by my provider. However, I further understand that I am not required to have these medications filled at the on−site Pharmacy and may take these prescriptions to any pharmacy of my choice.

Patient Signature:_____Date: _____

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Medical History Form

Name: Last _____ First _____ M_____

Date of Birth: _____ Age _____ Sex: ____Male ____ Female

Current Medications:

Name of Medication	Strength	Directions

Any known Medication or Food Allergies? _____

YOUR present **Health Status** (*not family*)

YES	NO	
___	___	High blood pressure
___	___	Migraines?
___	___	Heart Attack?
___	___	Blood Clots?
___	___	Breast Cancer?
___	___	Ovarian Cancer?
___	___	Uterine Cancer?
___	___	Glaucoma?
___	___	Kidney Disease?
___	___	Prostate Cancer?
___	___	Asthma?

YES	NO	
___	___	Have you ever smoked?
___	___	Do you currently smoke?
___	___	Currently on birth control?
___	___	Possibility of pregnancy?
___	___	Currently breastfeeding
___	___	Thyroid Disease?
		If yes, Hypo? or Hyper? _____
___	___	Diabetes?
		If yes, Type I or Type 2? _____

What is your **Surgical History**?

_____

_____

_____

YOUR past **Medical History** (*not family*)

YES	NO	
___	___	Bulimia?
___	___	Anemia?
___	___	Kidney Stones?
___	___	Bleeding Disorder?
___	___	Cancer?
___	___	Anorexia?
___	___	Seizures?
___	___	Gout?

YES	NO	
___	___	Polycystic Ovarian Disease?
___	___	Drug Abuse?
___	___	Rheumatic Fever?
___	___	Osteoporosis?
___	___	ADD/ADHD?
___	___	Liver Disease?
___	___	Alcohol Abuse?

Please complete page 2.

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Medical History Form (continued)

If you answered YES to any on previous page...please explain:

_____

_____

Please list any other information about your medical history that we may have not asked.

_____

_____

Activity Self–Assessment: ***Check One***

1. _____ **Inactive**–no regular physical activity with a sit down job.

2. _____ **Light activity**–no organized physical activity during leisure time.

3. _____ **Moderate activity**–"occasionally" involved in activities such as weekend golf, tennis, jogging, swimming or cycling.

4. _____ **Heavy activity**–consistent lifting, stair climbing, heavy construction, etc...or "regular" participation in jogging, swimming, cycling or active sports at least 3 times per week.

5. _____ **Vigorous activity–**participation in extensive physical exercise for at least 60 minutes per session 4 times per week.

This information will assist us in assessing your particular problem areas and establishing your medical weight loss program. Please verify that you have answered the questions in this Medical History Form truthfully and to the best of your ability.

Signature: _____ Date: _____

Witness: _____ Date: _____ Time: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice describes the privacy practices of Northern Hospital of Surry County (the "Hospital") and certain hospital-based physicians who provide services to patients at the Hospital.

We are required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of your health information. Your health information includes, among other things, information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

This Notice tells you how the Hospital may use and disclose your health information, your rights as they relate to your health information, and how to complain if you believe your privacy rights have been violated.

How We May Use and Disclose Your Health Information: We may use and disclose your health information for a variety of important purposes described below.

1. We may use and disclose your health information without your authorization as follows:

- *Treatment:* We may use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose your health information to other health care providers who are participating in your treatment and to pharmacists who are filling your prescriptions.
- *Payment:* We may use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your insurance company.
- *Health Care Operations:* We may use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.
- *Organized Health Care Arrangement*: The Hospital and certain hospital-based physicians with which it contracts participate in an organized health care arrangement. The Hospital and those physicians participating in the organized health care arrangement may share your health information with each other as necessary to carry out treatment, payment, or health care operations relating to the organized health care arrangement.
- *Required by Law*: We may use or disclose your health information when such use or disclosure is required by federal, state, or local law and the use or disclosure complies with and is limited to the relevant requirements of such law.
- *Public Health Activities*: We may disclose your health information, including, but not limited to, vital statistics (including births and deaths), disease-related data, and information related to recalls of dangerous products, to public health authorities for public health activities.
- *Abuse, Neglect or Domestic Violence*: We may disclose your health information to a government authority when the disclosure relates to victims of domestic violence, abuse, or neglect, or the neglect or abuse of a child or an adult who is physically or mentally incapacitated.
- *Health Oversight*: We may use or disclose your health information to a health oversight agency for oversight activities authorized by law. For example, we may disclose your health information to assist in investigations and audits, eligibility for government programs like Medicare and Medicaid, and similar oversight activities.
- *Judicial and Administrative Proceedings*: We may disclose your health information in response to an appropriate subpoena or other lawful request for information in the course of legal proceedings, or pursuant to a court order.
- *Law Enforcement Purposes*: Subject to certain restrictions, we may disclose your health information to law enforcement officials. For example, we may disclose your health information to comply with laws that require the reporting of certain wounds or injuries or to assist law enforcement in identifying or locating a suspect, fugitive, or missing person.
- *Coroners/Medical Examiners*: We may disclose your health information to a coroner or medical examiner for the purpose of identifying a decedent, determining a cause of death, or for other purposes as necessary to enable these parties to perform their duties. We may also disclose your health information to a funeral director as necessary to carry out his/her duties.
- *Organ Donation*: We may use or disclose your health information to organ procurement organizations when the use or disclosure relates to organ, eye or tissue donation and transplantation.
- *Research*: Subject to certain restrictions, we may use or disclose your health information for medical research.
- *Serious Threat to Health or Safety*: We may use or disclose your health information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, may only be to someone able to help prevent the threat.
- *Military and Special Government Functions*: If you are a member or a veteran of the armed forces, we may use or disclose your health information as required by military command authorities. We may also disclose your health information for national security, intelligence, or similar purposes.
- *Inmates*: If you are an inmate of a correctional institution or otherwise in the custody of a law enforcement official, we may disclose your health information to the correctional institution or law enforcement official when necessary for the correctional institution to provide you with health care, to protect your health and safety or the health and safety of others, or for law enforcement on the premises of, or the administration and maintenance of, the correctional institution.
- *Workers Compensation*: We may disclose your health information to comply with workers compensation laws or similar programs providing benefits for work-related injuries or illness.
- *Limited Marketing and Fundraising:* We may use or disclose your health information when the use or disclosure is permitted for marketing purposes, such as when a marketing communication occurs in a face-to-face meeting with you or concerns promotional gifts of a nominal value. We may also use your health information to contact you to raise funds for the Hospital, and you have the right to opt-out of receiving such fundraising communications. If you do not wish to be contacted for fundraising activities, you must notify the Privacy Officer in writing at the address provided below.
- *Appointment Reminders*: We may use your health information to contact you with appointment reminders. We may also use your health information to provide information to you about treatment alternatives or other health-related benefits and services that may be of interest to you.
- *Business Associates*: We may use or disclose your health information when the use or disclosure is necessary for our business associates, such as reference laboratories or consultants, to provide services to, or provide business functions for, the Hospital. To protect your health information, we require business associates to sign specialized agreements designed to safeguard your health information in their hands.

2. We may use and disclose your health information for the following purposes only after giving you an opportunity to agree or to object to the use or disclosure and you have either agreed or not objected to the use or disclosure:

- *Involvement in Care*: We may disclose your health information to family members, other relatives, or your close personal friends if the information is directly relevant to the family's or friend's involvement in your care or payment for that care, and you have either agreed to the disclosure or have been given an opportunity to object and have not objected to the registration clerk or the Privacy Officer. If you are not present or able to agree or object, or if there is an emergency situation, we may disclose your health information to your family or friends if we determine the disclosure is in your best interest. We may also disclose your health information to notify, or assist in the notification of, a family member, relative, friend or other person identified by you of your location, general condition or death.
- *Facility Directories:* We may share your name, your room number, and your general condition (stable, fair, good) in our patient listing with clergy and with people who ask for you by name. We also may share your religious affiliation with clergy.

- *Disaster Relief*: We may share your health information with a public or private agency (for example, American Red Cross) for disaster relief purposes. Even if you object, we may still share the health information about you, if necessary, in emergency circumstances.

3. In any situations other than those described above, we will ask for your written authorization before using or disclosing your health information. If you choose to sign an authorization to allow us to use and disclose your health information, you can later revoke that authorization to stop any future uses and disclosures by contacting the Privacy Officer. However, you cannot revoke your authorization for uses and disclosures that we have made in reliance upon such authorization.
HIPAA specifically requires that we obtain your authorization for the following uses and disclosures:
- *Psychotherapy Notes*: We must obtain your authorization for any use or disclosure of psychotherapy notes, except to carry out certain treatment, payment or health care operations functions or as otherwise required or permitted by HIPAA.
- *Marketing*: We must obtain your authorization for any use or disclosure of your health information for marketing purposes, except if the marketing communication is in the form of a face to face communication or a promotional gift of nominal value. If the marketing involves financial remuneration to us, the authorization you sign to permit such marketing must state that remuneration is involved.
- *Sale of Health Information*: We must obtain your authorization for any disclosure of your health information that is a sale of health information. If we obtain your authorization for this purpose, the authorization must state that the disclosure will result in remuneration to us.

In the event that North Carolina law or another federal law requires us to give more protection to your health information than stated in this Notice or required by HIPAA, we will provide that additional protection. For example, we will comply with North Carolina law relating to communicable diseases, such as HIV and AIDS. We will also comply with North Carolina law and federal law relating to treatment for mental health and substance abuse issues.

Individual Rights: You have the following rights with regard to your health information. Please contact the Privacy Officer at the number or address below to obtain the appropriate forms for exercising these rights:
- *Request Restrictions:* You may request restrictions on uses and disclosures of your health information to carry out treatment, payment or healthcare operations described above or to persons involved in your care or for notification purposes. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions. If you request that your health information not be disclosed to a health plan, we must agree to that restriction if the disclosure is for the purpose of payment or health care operations and is not otherwise required by law and the health information pertains solely to a health care item or service for which your or someone on your behalf (other than the health plan has paid us in full.
- *Confidential Communications:* You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.
- *Inspect and Obtain Copies:* In most cases, you have the right to inspect and obtain a copy of your health information. There will be a charge for the copies, postage and the costs of providing a summary of the health information provided, as applicable.
- *Amend Information:* If you believe that health information in your record is incorrect, or if important health information is missing, you have the right to request that we correct the existing information or add the missing information. If we deny your request for an amendment, correction, or update, we will provide an explanation of our denial and allow you to submit a written statement disagreeing with the denial.
- *Accounting of Disclosures:* You may request a list of instances where we have disclosed health information about you during the previous six years. The list will not include certain disclosures including, but not limited to, disclosures for treatment, payment, or health care operations, disclosures pursuant to an authorization, or disclosures for the facility's directory or to persons involved in your care. In the event we make disclosures of your health information through an electronic health record, the list will include disclosures for treatment, payment, and health care operations made during the previous three years.
- *Copy of Notice*. You may request a paper copy of this notice at any time.

Our Legal Duty: We are required by law to protect and maintain the privacy of your health information, and we are required to notify you of any breach of your unsecured health information. We are required by law to provide this Notice about our legal duties and privacy practices regarding your health information and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices: We reserve the right to change our privacy policies and the terms of this Notice at any time and to make the new policies and provisions effective for all health information that we maintain at that time. You may obtain a revised Notice at any time by contacting the Privacy Officer or by going to our website at ***www.northernhospital.com***.

Contact Person: For more information about our privacy practices, contact our Director of Health Information Management-Privacy Officer at (336) 719-7000, ext. 5113, or write to:

Northern Hospital of Surry County
Director of Health Information Management/Privacy Officer
PO Box 1101
Mount Airy, NC 27030

COMPLAINTS: If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact our Privacy Officer at the address and/or phone number above. You also may send a written complaint to the U.S. Department of Health and Human Services:

Region IV, Office for Civil Rights
US Department of Health and Human Services
Atlanta Federal Center, Suite 3B70, 61 Forsyth Street, SW.
Atlanta, GA 30303-8909
Phone (404) 562-7886 or FAX (404) 562-7881

You will not be penalized in any way for filing a complaint.
Rev. 1/2009; 9/13. **Effective Date:** The effective date of this Notice is September 23, 2013.
WCSR 31225974 v1