Clayton Medical and Vascular Center

REGISTRATION FORM

Today's Date:			PCP:		
PATIENT INFORMATION					
Patient's last name: First:		Middle:	Marital status:		
Is this your legal name? ○ Yes ○ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: ○ M ○ F
Address: [Address/ P.O Box, City, ST ZIP Code]					
Social Security no.:	Home phone no.:		Cell phone no.:		
Occupation:	Employer:		Employer phone no.:		
Chose clinic because/referred to clinic by (Please choose one option): ○ [Doctor's name] ○ [Choose an item]					
Other family members seen here: [Other patients]					
INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:		
Is this person a patient here? ○ Yes ○ No		Is this patient covered by insurance?	○ Yes ○ No		
Occupation:	Employer:	Employer address:	Employer phone no.:		
Please indicate primary insurance: [Choose an item] | Other: [Other insurance]					
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber: [Choose an item] | Other: [Relationship to subscriber]					
Name of secondary insurance (if applicable):		Subscriber's name:	Group no.:	Policy no.:	
Patient's relationship to subscriber: [Choose an item] | Other: [Relationship to subscriber]					
IN CASE OF EMERGENCY					
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.:	Work phone no.:	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Clayton Medical and Vascular Center or insurance company to release any information required to process my claims.

Patient/Guardian signature _____ Date _____

Clayton Medical & Vascular Center
Alan Nadour, M.D.
Internal Medicine & Vascular Medicine

101 Winding Wood Drive
Clayton, NC 27520

Phone: (919) 553-1911
Fax: (919) 553-3993

Authorization to Release Information

Patient Name:----------DOB:----------

------ I hereby request a copy of my medical records as Indicate below, be released to me.

------ I elect to have these records mailed to me; records will be ready in twenty one (21) business days.

------ I elect to pick these records up in person; records will be ready in twenty one (21) Business days.

------ I consent to and authorize: Name of physician/Facility----------

Address: ----------to release my medical records to as indicated below to Clayton Medical & Vascular Center, NC

------ I consent to and authorize Clayton Medical & Vascular Center, NC to release my medical records as indicated below, to (physician/Facility's Name)----------Phone:----------

Address:----------City:----------State:----------Zip:----------

Treatment Dates Form:----------To:----------

------ History & Physical ------ Operative / Procedure ------ Consults/ Office/ Notes
------ Emergency Department Notes ------ Labs/ X-rays/ EKGs
------ Consults, Progress Notes (Hospital)
------ Other (Specify)----------

I Do------- I Do Not------ authorize the release of portions of the record relating to substance abuse, psychological/ psychiatric conditions and/or communicable diseases, including immunodeficiency virus (HIV), if present.

The information to be released will be used for the following purpose (check appropriate box):

------ Sharing with other health care providers as needed ------ Insurance Processing
------ Legal reasons ------ Personal Use
------ Other (specify)

I understand that I may revoke this consent at any time I writing except to the extent to the extent that the information has already been released pursuant to this consent and before I have revoked my consent. Otherwise, this consent shall continue to be valid only for as long as reasonable necessary to carry out the purposes enumerated above or unless it is with release to an insurance company for payment for medical and/or hospitalization benefits, it will automatically expire one year after date signed, whichever is the earliest date. I have been informed and understand that information disclosed pursuant to this authorization may be subject to re-disclosure by a recipient of such information. It is that once disclosed. The privacy of the information will no longer be protected under federal medical privacy law.

Note: Unless otherwise permitted by law, further release of this information is prohibited without prior written consent.

Signature of patient or legal representative ----------Date: ----------
Pease Print Name:----------State relationship to patient:----------Phone Number: ----------
Signature of Witness: ----------Date: ----------
Please Print Witness Name: ----------Authorization not valid beyond: ----------

CLAYTON MEDICAL AND VASCULAR CENTER

PATIENT HISTORY FORM

GENERAL INFORMATION

❑ How did you hear about our practice? ❑ Physician ❑ Internet ❑ Telephone Book ❑ Family Member ❑ Friend
❑ Other _____

❑ What is the reason for your visit today?

_____

_____

How long has this bothered you? ❑ 1 ❑2 ❑3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ Days ❑ Week ❑ Months ❑ Years

❑ What treatments have you tried and have they been effective? _____

_____

❑ On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? ___/10

❑ The pain quality is: ❑ Burning ❑ Constant ❑ Dull ❑ Sharp ❑ Shooting ❑Throbbing ❑ Tingling ❑ Other _____

CURRENT MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what?
Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug	Dose (include strength & number of pills per day)	How long have you been taking this?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Over-the-Counter Medications/Vitamins/Herbals

Name of Medication	Dose (include strength & number of pills per day)	Frequency
1.		
2.		
3.		
4.		
5.		

Medical History

Do you now or have you ever had:

- ❑ Diabetes (type 1,Type 2)
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Blood disorders
- ❑ Liver
- ❑ Cancer (type) _____
- ❑ Neuropathy (specify) _____
- ❑ Arthritis (specify) _____
- ❑ Kidney disease
- ❑ Stroke
- ❑ Other medical conditions (please list):
- ❑ Are you pregnant ❑Yes ❑ No
- ❑ Are you nursing ❑ Yes ❑ No

- ❑ Heart murmur
- ❑ Alcoholism
- ❑ Sleep apnea
- ❑ Stomach/bowel
- ❑ Gout
- ❑ Depression
- ❑ Thyroid disease (specify) _____
- ❑ Circulation problems
- ❑ Hepatitis
- ❑ Kidney stones

- ❑ Allergies
- ❑ Anxiety disorder
- ❑ Musculoskeletal
- ❑ Heart disease
- ❑ Mental illness
- ❑ Skin disorders
- ❑ Breathing issues
- ❑ Asthma
- ❑ HIV/AIDS
- ❑ CVA

Surgical History

Do you now or have you ever had:

- ❑ None
- ❑ Angioplasty
- ❑ Cholecystectomy
- ❑ Appendectomy
- ❑ Bypass
- ❑ C-Section
- ❑ Cataracts
- ❑ Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? ❑ Yes ❑ No
  If yes please describe
- ❑ Do you have any artificial joints ❑ Yes (Where?) ❑ No
- ❑ Do you have an artificial heart valve ❑ Yes ❑ No

Social History

- ❑ Do you smoke? ❑ Yes ❑ No If yes how many packs a day? ❑ 1 ❑ 2 ❑ 3 ❑4 ❑ 5 for how long?
- ❑ Do you drink alcohol? ❑ Yes, everyday (5-7 days/week) ❑ Yes, occasionally/socially ❑ No/Rarely
- ❑ Substance abuse ❑ Yes, I have a current substance abuse problem. Please specify _____
- ❑ Yes I had a past substance abuse problem. Please specify _____
- ❑ No I have never had a substance abuse problem
- ❑ What is your occupation? _____ Does it involve mostly ❑ Standing ❑ Sitting
- ❑ Do you exercise regularly? ❑ No, I do not exercise regularly ❑ Yes, I do the following regular exercise: _____

Family History

- ❑ Alzheimer
- ❑Blood Clot
- ❑ Circulation problems
- ❑ Emphysema
- ❑ Neurological
- ❑ Arthritics
- ❑ Cancer
- ❑ Depression
- ❑ Heart Disease
- ❑ Strokes
- ❑ Bleeding disorder
- ❑ Cataracts
- ❑ Diabetes
- ❑ High blood pressure
- ❑ Other _____

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

EYES
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

HEART AND LUNGS
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

SKIN
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet

BLOOD
- ❑ Anemia
- ❑ Clots

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination
- ❑ Blood in urine

Women Only:
- ❑ Abnormal Pap smear
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Difficulties with sexual arousal
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Frequent crying
- ❑ Sensitivity
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Racing thoughts
- ❑ Hallucinations
- ❑ Rapid speech
- ❑ Guilty thoughts
- ❑ Paranoia
- ❑ Mood swings
- ❑ Anxiety
- ❑ Risky behavior

OTHER PROBLEMS:

WOMENS REPRODUCTIVE HISTORY:

Age of first period:
Pregnancies:
Miscarriages:
Abortions:
Have you reached menopause? Y / N At what age?
Do you have regular periods? Y / N

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Tel (919) 553-1911 / Fax (919) 553-3993

www.claytonmvc.com

Date: _____

I understand there will be a $25.00 fee charge for all **No Show Appointments** and **Cancellations** that are not reported at least 24 hours prior to appointment time.

We recognize there are emergencies and compelling circumstances that will be taken into consideration.

Patient's Name: _____

Patient's Signature: _____

Lab Work:
Lab work is done in our office by one of the Nurses and sent out to LabCorp for processing.

Complete Physical Exams:
We believe that routine, annual complete physical exams with screening lab tests are very important to the maintenance of good health. However, insurance benefits vary. Some policies cover "wellness" and others cover visits when you have a complaint. Please learn about your benefits prior to your appointment so you will know what is covered by your insurance plan.

Prescriptions and Refills:

- The best time to get a prescription refill is at your appointment.

- Call your pharmacy 14 days before your prescription runs out and have the pharmacist fax over a refill request. It will take us 3 business days to refill your request. If you don't have any other refills on your prescription then please call our office 14 days before you run out to make an appointment for follow up to your medicaiton.

- Don't go to the pharmacy to wait for your prescription to be called in. Call them first to see if it is ready. We require check-ups every 3 or 4 months for certain medications. Be sure to keep those follow-up appointments. Some prescriptions cannot be called in. The prescription must be printed for you to pick up.

- Don't call after hours for prescription refills. There is no access to your chart and we may not be able to help you.

- Narcotics: We do not prescribe narcotics for chronic use. We do not call in narcotics after hours. If you require use of narcotics, our physicians will refer you to a pain management specialist.

- Mail Order Prescriptions: Many insurance plans offer financial incentives for using mail order pharmacies. We are glad to print out prescriptions for your mail order pharmacy needs. You can pick these up at our office. We do not fax or call in mail orders.

Referrals:
Referrals are handled by our Referral Department. This can take 2-3 days, depending on your insurance and/or the urgency of your situation. It is your responsibility to know if your insurance requires a referral for treatment to a specailist please do not make an appointment with a specialist until you have contacted your insurance company to find out it you need a referral then contact us and we will start the referral process. Someone will contact you as soon as the referral authorization is obtained. As a patient, it is your responsibility to ensure that your specialist is on your plan. Please understand that it can sometimes take a few weeks to get an appointment with a specialist. This is not something we have control over.

Dismissal:
If you are "dismissed" from the practice it means you can no longer schedule appointments, get medication refills or consider us to be your doctor. You have to find a doctor in another practice.
Common Reasons for Dismissal
• Failure to keep appointments, frequent no-shows
• Noncompliance, which means you won't follow physician instructions about an important health issue
• Abusive to staff
• Failure to pay your bill Dismissal Process We will send a letter to your last known address, via certified mail, notifying you that you are being dismissed. If you have a medical emergency within 30 days of the date on this letter, we will see you. After that, you must find another doctor. We will forward a copy of your medical record to your new doctor after you let us know who it is and sign a release form. A COPY OF THIS FORM WILL BE PROVIDED AT YOUR REQUEST. PLEASE INFORM THE RECEPTIONIST.

Financial Policies:
We would like to thank you for choosing Clayton Medical and Vascular Center as your medical provider. We have written this policy to keep you informed of our current financial policies. No Insurance: Payment will be due at the time of service. If you are unable to pay your balance in full, you will need to make prior arrangements with our Accounts Manager or a Customer Service Representative.

Insurance: Although we are contracted with several insurance companies, it is your responsibility to make sure that our physician is in your plan. It is also your responsibility to know your insurance benefits. As a courtesy to our patients we will file primary insurance forms from our office. In order to do this we will require information from you. We will need all your demographic and insurance information prior to your appointment. We will also request an update on this information approximately every six months thereafter. We ask that at the time of your appointment you bring your insurance card and a photo ID as well as any other forms that will assist in making sure that your claim is

filed correctly. At the time of service you will be responsible for all fees that are not covered by your insurance, including co-pays, co-insurance, deductibles and non-covered services or items received. The co-pay cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier. We strive to be as accurate as possible in calculating your responsibility but, with so many variations in policies and fee schedules, we are not always exact. You may receive a statement from our office for any balance due. For your convenience we accept cash, checks, credit cards (Visa, MasterCard, American Express and Discover), and money orders. Payments are also accepted by phone.

Return Checks:
Returned checks are handled through TeleCheck at 1-800-366-1054. There will be a charge assessed for any check returned by your bank for any reason.

Disability, Insurance Forms, Attending Physician Statements, FMLA:
There will be a charge of $25.00 for the completion of medical forms or you may be required to schedule an appointment. Payment is due at the time that you pick-up these forms. Please allow 7-10 days for the completion of these forms. If you would like the forms mailed to you or the insurance, payment will be due prior to mailing. FMLA forms require that you come in for an appointment.

Medical Records:
We will provide you a copy of your medical records upon request and for a fee. You will need to sign a letter of release prior to having them copied. Please allow up to 30 days for this request to be processed.

Lab Work:
A limited number of lab services will be billed by our office. All other services will be billed by the contracted lab. You may receive a bill from LabCorp, please contact their billing department prior to calling our office. We do not have access to their billing information.

Billing:
If you receive a bill from us, it is because we believe the balance is your responsibility. Please contact your insurance company first, if you think there is a problem. If you have any questions about your bill, please call our billing department immediately. If you cannot pay your entire balance, please call to make payment arrangements.

Collections:
Accounts that are not paid within 30 days begin our in house collection process. If your balance becomes 65 days old, your doctor will be notified and appropriate actions will be taken.

Thank you,

Dr. Alan M. Nadour, M.D.

Patient Acknowledgement:

I acknowledge that I have received and read a copy of the Clayton Medical and Vascular Center Office and Financial Policies.

_____ Signature/Patient or Guardian

_____ Date