Clayton Medical Health & Vascular

101 Winding Wood Drive Clayton, NC 27520
919-553-1911

Patient Intake Form

Full Name: ______________________________ DOB: ________________
Address: ____
City: ________________________ State: ____________ Zip: __________
Phone # _____________________ Email: ___________________________
Occupation: ____

Emergency Contact 1: ______________________ Phone #_______________
Relationship: ____________________________
Emergency Contact 2: ______________________ Phone #_______________
Relationship: ____________________________

Current/Previous Primary Care Provider: ______________________________
Address: ____
City: ________________________ State: ____________ Zip: __________
Phone # _____________________

Medical History

Past Medical History: ____
____
____

Surgical History: ____
____
____

Patient Signature: ____________________________ Date: ____________

Medication List

Medication Name (Prescribed and Over the counter)	Dose (How much)	Frequency (How Often)

Allergies: ____
____
____
____

Pharmacy Name: ____
Address: ____
City: ____________________ State: ______________ Zip: ____________

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

101 Winding Wood Dr
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 indicated below, to be released to me.
___ I elect to have these records mailed to me; records will be ready in 21 business days.
___ I elect to pick these records up in person; records will be ready in 21 business days.
___ I consent to and authorize: Name of physician/Facility ________________
Address: ______________________________ to release my medical records as indicated below to Clayton Medical Health, NC.
___ I consent to and authorize Clayton Medical Health, NC to release my medical records as indicated below to (Physician/Facility Name) ________________
Phone: __________ Address: ______________________
City: ______________ State: __________ Zip: __________

Treatment Dates From: ________________ To: ________________

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

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 in writing except 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 reasonably 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 __________
Please Print Name: ______________ Relationship to patient: __________ Phone: __________
Signature of witness: ______________________ Date: __________
Print Witness name: ______________________ Authorization not valid beyond: __________

HIPPA FORM FOR CLAYTON MEDICAL HEALTH & VASCULAR

Name: ______________________________

Authorization to Contact Patient and Record of Disclosure (HIPPA):
The HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (CHECK ALL THAT APPLY):

____ OK to give detailed information via Voicemail, E-mail, or Text

____ Leave a message with office call back number only via Voicemail, E-mail, or Text

____ Other: ____

I authorize the release of protected health information to the individual(s) listed below:
Name: ___________________________ Phone: ______________________
Relationship: _____________________
Name: ___________________________ Phone: ______________________
Relationship: _____________________

I understand that I may revoke this authorization at any time by submitting a written request.

Patient/Guardian Signature: ____
Printed Name: _________________________________ Date: __________________

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Patient Responsibilities

- You are responsible for providing us at the time of service with insurance information or any updates to your health insurance plan.
- You are responsible for providing our office team with updates to your address or telephone number, as well as the updated information of the person who is financially responsible for your bills.
- You are responsible for the **$25.00 fee** charged for all No Show, Cancellation, and Reschedules that are not reported at least 24 hours prior to appointment time. We recognize that there are emergencies and compelling circumstances that will be taken into consideration.

Copays

- You are responsible for paying the required copayment at the time of each visit.
- If you do not have insurance, you will be expected to pay the self-pay amount at the time of the visit.
- If we cannot verify your insurance coverage at the time of your visit, you will be responsible for a minimum payment of $60.00.

Deductible

- It is your responsibility to know and understand your insurance plan and any deductible that may apply under your responsibility.
- Our billing staff will send you a statement that shows in detail the amount your insurance company has determined is applied to your deductible and is owed by you. You will be responsible for this payment.

Insurance Information

- Our billing department can assist patients with any billing questions but cannot resolve any disagreement between patient and insurance.
- Our billing team will be available to help if you need to know any service codes for you to verify with your insurance if the service is covered under your plan or not. It is your responsibility to verify all the information.
- Medical insurance may not cover the entire cost of your medical services. If we believe that a service we are going to provide is not covered by your insurance we will notify you. However, we do not learn that a service is not covered until we submit the claim to your insurance. You will be responsible for any payments your insurance refuses to pay.

Patient Signature: ______________________________ Date: ____________________