

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: _____

☐ I consent to and authorize Clayton Medical Health, NC to contact my primary care provider

Treatment Dates From: _____ To: _____

☐ History & Physical ☐ Operative/Procedure ☐ Consults/Office Notes

☐ Emergency Department Notes ☐ Consults, Progress Notes (hospital) ☐ Labs/X-rays/EKGs

☐ 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 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: _____

HIPAA FORM FOR CLAYTON MEDICAL HEALTH & VASCULAR

Name: _____

Authorization to Contact Patient and Record of Disclosure (HIPAA):

The HIPAA 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 will be responsible for any and all out-of pocket costs if you do not present all current active insurance information on each appointment date. It is your responsibility to notify the practice of what insurance plan(s) you are covered under.**
- You are responsible for providing our office 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.
- I acknowledge that any forms or paperwork requested (e.g., disability forms, FMLA, insurance documents, etc.) may take up to **7-10 business days** to be completed by the provider or office staff. I understand that I am responsible for submitting these requests in a timely manner to allow for adequate processing time.
 - Completion of complex forms often requires considerable time and research by our medical staff. As such, there is a fee of **\$25.00** for the completion of all types of forms. This fee is for administrative service and the provider's time which is not covered by insurance. Payment is due at the time you drop off or submit the forms.

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 copay at the time of 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: _____