Marion Wellness & Disease Management, PLLC | 59 Gypsy Mountain Rd Marion, NC 28752 | Office (828) 652-8196 | Fax (828) 652-8186

2018 REGISTRATION FORM HIGHLIGHTED AREAS REQUIRED (Please Print Clearly)

PATIENT INFORMATION

Patient's Full Name (as it appears on insurance card) _____

Name you prefer to be called _____ Email _____

How did you hear about us? _____ Who is your current primary care provider? _____

Mailing Address _____ City, State, Zip _____

Prefered Phone # (home/cell) _____ Alternate Phone # (home/cell) _____

Our office may send items by mail, contact you by phone, leave messages on voicemail or with the person who answers the Prefered Phone # you provide above. *This communication may include protected health information related to treatment, billing and healthcare operations* **I understand that I can change these preferences at any time with written notice and I will make sure to notify the office if my phone number(s) or address change.*

Patient's Date of Birth _____ Marital Status: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Patient's Social Security # _____ Occupation _____

Patient's Employer _____ Work Phone _____

Person Responsible for Bills (Guarantor) ☐ SELF, ☐ Other (please print full name): _____

Relationship to Patient _____ Address ☐ SAME AS PATIENT, ☐ Other _____

IN CASE OF EMERGENCY

Name _____ Relationship to Patient _____ Phone # _____

Our office may contact this person in the event of an emergency or in the event that we are unable to get ahold of you for treatment, billing and healthcare operations. This communication may include protected health information in accordance with our Notice of Privacy Practices. **I understand that I can change these preferences at any time with written notice.*

INSURANCE **if the patient is the Insurance Policyholder, you may skip this section*

Policyholder's Full Name (as listed on card): _____ Date of Birth _____

Relationship to Patient _____ Policyholder's Phone # _____

Mailing Address _____ City, State, Zip _____

Policyholder's Employer _____ Employer Phone _____

ASSIGNMENT OF INSURANCE BENEFITS, CONSENT OF TREATMENT & RECEIPT OF PRIVACY NOTICE (HIPAA)

I HEREBY ASSIGN my Medicare and/or medical insurance benefits to be paid directly to *Marion Wellness & Disease Management, PLLC* for the services rendered to me by *Kathleen Smothers, MSN, RN, ANP-BC*, employees or any person providing services through or on behalf of *Marion Wellness & Disease Management, PLLC*. I authorize any holder of medical information about me to release by electronic means or otherwise any medical and/or billing information concerning my care, including copies of my medical records as needed to determine these benefits payable for related services.

I understand that I am financially responsible for all non-covered services as well as any deductibles, copay/coinsurance or amounts in excess of insurance benefits. If coverage is denied, I give my express consent to appeal to the insurance on my behalf.

I GIVE CONSENT TO *Marion Wellness & Disease Management, PLLC,* its Practitioners, and employees to examine, evaluate and treat as deemed necessary for the above named patient.

This assignment and my consent will remain in effect until revoked by me in writing. A copy of this form shall have the same force and effect as the original.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE: I acknowledge that I have been presented with a copy of the Notice of Privacy Practices pamphlet, detailing how my information may be used and disclosed as permitted under federal and state law, the duty of *Marion Wellness & Disease Management, PLLC* to protect my health information, privacy rights, including the right to complain to HHS and to *Marion Wellness & Disease Management, PLLC* if I believe my privacy rights have been violated and how to contact *Marion Wellness & Disease Management, PLLC* for more information or to make a complaint.

_____ _____

(Signature of patient, parent or legal guardian of patient) (Date signed)

_____ _____

(Employee Witness) (Date signed)

OVER. PLEASE

Patient Authorization to Disclose, Release and/or Obtain Protected Health Information

INFORMATION TO BE RELEASED FROM: *(Include name of facility/person, address, fax #)*	INFORMATION TO BE RELEASED TO: *(Include name of facility/person, address, fax #)* **Marion Wellness & Disease Management, PLLC** **59 Gypsy Mountain Rd** **Marion, NC 28752** **Phone (828) 652-8196** **Fax (828) 652-8186**

PRINTED PATIENT NAME: _____ **DATE OF BIRTH** _____

Type of Information (*check appropriate box*):

- ☐ Visit notes from date: _____ to date: _____
- ☐ All Medical Records from date: _____ to date: _____
- ☐ Whole Chart
- ☐ Images (*specify, e.g.: radiology, endoscopy*) _____
- ☐ Other (*specify, e.g.: discharge summary, operative reports, lab reports, billing*) _____

Purpose of Disclosure: □Health Care □Insurance □Legal □Personal □Other (*specify*): _____
*Only records originated through *Marion Wellness & Disease Management, PLLC* will be copied, unless otherwise requested.

I understand that:

- My records may contain private information regarding the diagnosis and/or treatment of illnesses like hepatitis, HIV/AIDS, sexual diseases, substance abuse, and/or mental illness
- *Marion Wellness & Disease Management, PLLC* has no control over how my Protected Health Information will be used by the people who receive it
- *Marion Wellness & Disease Management, PLLC* will not base treatment or payment decisions on receipt of this signed authorization
- I have the right to inspect or obtain a copy of my protected health information and this signed authorization
- A photocopy and/or facsimile of this authorization may be considered as valid as the original
- Fees may be charged for the copying of records in accordance with federal and state laws, there is no charge to send copies of your medical record directly to another health care provider
- Without my express revocation, this authorization will automatically expire upon satisfaction of the need for disclosure; or the following specific date (*optional*): _____
- I can revoke this authorization in writing and that the revocation will not apply to information that has already been released in response to this authorization

By signing this page, I release *Marion Wellness & Disease Management, PLLC* its employees and health care providers from any legal responsibility or liability for this disclosure. I further acknowledge that I have read, understand and agree to the terms above:

_____ _____
(Signature of patient, parent or legal guardian of patient) (Date signed)

_____ _____
(Employee Witness) (Date signed)

2018 FINANCIAL/PAYMENT POLICY

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. To better address questions regarding patient and insurance responsibility for services, we developed this financial/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. Effective January 1st, 2018**

PAYMENT METHOD	It is our policy to collect payment (co-payment, deductible, coinsurance etc.) **at CHECK-IN**. We accept all forms of payment including cash, checks, and debit/credit cards. We also accept debit/credit card payments over the phone. We do not accept postdated checks. If a check is returned, you will be charged a $35 fee in addition to the amount of the check. If you have a second check returned, you will be asked to pay by cash or debit card for all future visits.
SELF PAY *Patients with no insurance or if we are not covered by your insurance plan*	Payment in full is expected **at CHECK-IN**. New patients with no insurance are asked to pay $300.17 toward their initial visit; established patients are asked to pay $210.53 toward their visit. Please note that this is a deposit on your visit and that your visit may cost more or less than this amount.
INSURANCE	Our practice must obtain a copy of **your driver's license and valid insurance card** to provide proof of insurance. We participate in most insurance plans, including Medicare. **If you do not bring your current insurance card, you will be considered a SELF-PAY patient (see above) until we can verify coverage**. If your insurance changes, please notify us before your visit and bring the new card so we can make appropriate changes, otherwise you risk being responsible for the balance of any claim(s) filed under the wrong information.
INSURANCE *Co-payments and deductibles*	It is our policy to collect payment (co-payment, deductible, coinsurance etc.) **at CHECK-IN**. **If you are unable to make your payment according to the terms of your insurance policy, you will be asked to reschedule**. If this happens more than once, all future incidents will be marked as a missed appointment and you will be charged a NO SHOW fee (see missed appointments below) for each. For any questions regarding co-pays/deductible, please contact your insurance company.
INSURANCE *Non-covered services*	**PLEASE BE AWARE:** some services you receive may not be covered by insurance. You may be responsible for the balance of any uncovered claim(s) or asked to pay for these services in full at the time of visit. Please be aware any treatment for a chronic or new illness and 'non-preventative' tests or procedures that may be provided during a **Preventive Physical Exam may not be covered by your insurance**. **You will receive separate bills for laboratory and other outside services.** We cannot guarantee that these services are In-Network or covered with your insurance. Please contact your insurance company with any questions
INSURANCE *Claims submission*	**As a courtesy to you**, we will submit your claims and assist you in any way we reasonably can. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request(s). Once your insurance has processed the claim, you will receive a bill from our practice for any outstanding balance. This balance is what your insurance company has determined to be your responsibility and is due upon receipt of the bill. Your benefits are a contract between you and your insurance company; we are not party to that contract. Please contact your insurance company with any questions.
RESCHEDULED, CANCELED AND MISSED APPOINTMENTS	Life happens, we understand… if you're running late let us know. With notice, we will work you into the schedule as a walk-in once you check-in. **In consideration of our staff and other patients we ask you to notify us 24 hours prior to your scheduled appointment time if you need to reschedule or cancel your appointment. This allows us to work in patients on a waiting list or those who are sick.** While we make every effort to provide a courtesy reminder call prior to your visit, it is your responsibility to cancel your appointment. We do charge a NO-SHOW FEE for appointments not canceled/rescheduled within 24 hours of appointment time ($30 for most appointments; $100 for physicals). If you are more than 15 minutes late for an appointment, **without notice**, your appointment will be considered missed and you will be charged a NO SHOW fee. These charges will be your responsibility. More than 3 "NO SHOWS" may result in you being discharged from this practice. OVER. PLEASE

COPIES OF MEDICAL RECORDS	Your medical records are available through our online Patient Portal **at no cost to you**. If you wish to have a hardcopy of your records, you will be charged for the cost of copying the record and any postage needed. This charge must be paid in full before records are available. [According to NC Statute GS90-411, our fee schedule is $0.75 for pages 1-25, $0.50 for pages 26-100, and $0.25 for pages 101-plus, with a minimum fee of $10.00.] Upon written request (authorization to release medical records), a copy of your medical records can be sent directly to another healthcare provider at no charge.
WORKERS' COMPENSATION LIABILITY / MOTOR VEHICLE ACCIDENTS	**WORKERS COMPENSATION –** It is your responsibility to file a report with your employer. If you are injured on the job, please let the receptionist know, **when you call to schedule an appointment**, so we may contact your employer to facilitate filing your claim. We do require you to provide your health insurance information. In the event that workers compensation is denying your claims, we will file your claim with your health insurance, and look to you for payment of any balance. If you have retained legal representation for your workers compensation case, we ask that you provide us with their name and address. Please be aware that we cannot be expected to wait for the conclusion of a lengthy settlement before being paid. **LIABILITY/MOTOR VEHICLE ACCIDENT** – It is your responsibility to file any necessary reports. In the case of motor vehicle accidents please bring your automobile insurance card and your health insurance information. In any legal case where another party is presumed liable for your expense, we look to you (the party receiving service) for payment. Until your claim is settled, you will be responsible for your charges. **We do not bill attorneys or wait for settlements.** You will need to use your health insurance if available or you will be considered self-pay. We will provide your attorney/liability insurance carrier with a copy of your bill upon request.
COMPLETION OF FORMS *Including, but not limited to: Insurance forms, Family Medical Leave Act, disability applications, medical clearance letters, letters of medical necessity, etc.*	An office visit, to determine medical necessity, is required from most of these companies. This visit must be prior to completion of most medical forms. ● Due to the increasing volume of forms and letters that are being requested, and the time it takes away from direct patient care we do charge a nominal fee for this service: processing fee $30. ● Patients with an outstanding balance will be required to make a payment toward their balance in addition to the processing fee. ● Our staff will begin processing the forms for completion after payment is received in full.
NONPAYMENT *Delinquent accounts*	Due to the high cost of rendering care and lowered reimbursements we simply cannot afford to carry large balances. Outstanding balances, **over 90 days,** will receive a letter requesting payment in full, within 30 days, to avoid collection action. Please be aware that if your account becomes delinquent, we may refer it to a collection agency. You agree to pay any charges to collect your unpaid bills, including but not limited to, reasonable court costs, and/or collection agency fees. Delinquent accounts may result in your discharge from this practice, you will be notified by certified mail.

By signing the financial responsibility statement, the patient and guarantor(s) acknowledge and agree they are responsible for payment of services rendered or to be rendered. The patient and guarantor(s) guarantee and agree to pay charges for those services rendered including any amount not covered by insurance, Medicare, health service plan or health maintenance organization. This financial responsibility statement will remain in effect until an updated statement is signed and submitted taking it's place; or it is revoked by me in writing. A copy of this statement shall have the same force and effect as the original. I acknowledge that I have read and understand the FINANCIAL/PAYMENT POLICY and FINANCIAL RESPONSIBILITY STATEMENT contents fully:

_____ _____

(Signature of patient, parent or legal guardian of patient) (Date signed)

_____ _____

(Employee Witness) (Date signed)

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YOUR HEALTH FILE: PATIENT PORTAL

Marion Wellness & Disease Management, PLLC is committed to providing you with the highest quality of care. To enhance your experience we offer a **secure** and **FREE** Patient Portal which includes:

- Enhanced communication with your healthcare team via secure messaging, no more waiting for a return phone call!
- Access to your medical record, visit notes, lab and other tests results
- **Appointment Check-in** through your portal, skip the paperwork!
- **Request Rx refills**
- **Self-Scheduling**: request a 'sick visit'
- Access to your account balance and statements **payments can be made by calling our office (828) 652-8196 during business hours*

*****Patient Portal communication is NOT to be used for emergency or urgent medical services: PLEASE CALL 911 IF YOU BELIEVE THAT YOU ARE EXPERIENCING A MEDICAL EMERGENCY.**

Full Name of patient:
Email address print clearly:

WHAT NEXT…

1. We will add your email, then you will receive an email from: **HFAlerts@nextgen.com** with the subject line "Activate your YourHealthFile Patient Portal account"
   *****TIP***: *this email expires after a few days*
2. Click the link in the email to register "**Click here to begin the registration process**"
   *****TIP***: *write down the username and password you pick so you don't forget it*!
3. **After** you've registered go to **YourHealthFile.com** log in with the username and password you chose, explore and bookmark the site. That is your Patient Portal.
   *****TIP:*** *Our system does not work with Internet Explorer, Supported browsers include:*

Mozilla Firefox *Google Chrome* *Apple Safari*

If you have any trouble accessing your account call us *(828) 652-8196*

The best time to call with questions is Wednesday mornings from 8am-12noon

Welcome to *Marion Wellness*, we are honored that you chose us to be your primary care provider. Our practice believes in early detection, early intervention and prevention. Regularly scheduled office visits allow us to better assist you in identifying and managing chronic and acute health conditions.

We strive to provide the highest quality of care in a timely and respectful manner. Our office is open **Mon-Tue**: 8am - 5pm **Wed**: 8am - 12pm **Thu**: 7am - 4pm and **Fri**: 8am - 5pm for scheduled appointments. Our nurses are also available to assist walk-ins for sick visits (*common cold, sore throat, earache, urinary tract infections, flu, etc.*), breathing treatments, ECG, Spirometry or other laboratory testing.

We work very hard to stay on schedule. Rarely emergencies and urgent work-in visits may delay scheduled appointment times. These types of visits are given priority to keep our patients safe and out of emergency rooms. We appreciate your understanding and patience in regard to these delays.

With our goal of providing the highest quality of professional care to our patients, the following guidelines for refills and new medications have been established:

1. Regularly scheduled visits are necessary to evaluate and possibly adjust medications before refilling; please schedule your visit for a time before you will run out of medication(s). Outside of an office visit, we ask that you request refills through your pharmacy.
2. For the safety and well-being of our patients, requests for new medications (including antibiotics) will not be approved without an appointment for clinical evaluation of your symptoms.

Before your first visit:

☐ Please call the customer service number listed on your insurance card to notify them of your new primary care provider: **Kathleen Smothers, MSN, RN, ANP-BC**. Please also ask about any co-payment, deductible or coinsurance amounts you may be responsible for.

☐ Complete the attached forms and bring them with you to your visit. **We will ask that you fill out new registration forms yearly*

Please arrive 15 minutes early for your appointment and bring the following to <u>every visit</u>:

1. Photo identification (driver's license) and a copy of your Health Insurance <u>and</u> Prescription card(s)
2. Your payment, which is to be paid at <u>check-in</u>:
    - Insured: your co-payment, deductible and/or coinsurance amount
    - Self-Pay: **Please read the Financial/Payment Policy section about SELF PAY*
3. All medications you are taking including over the counter medications (or a list with the name, dose, how often you take it and what it is for)

**Not having your health insurance card(s) and/or a valid form of payment, at check-in, may result in your appointment being rescheduled*

As a courtesy, we do try to call to remind you of your scheduled visit. If you have any questions or need to reschedule please call during office hours to speak with our staff or you can leave a message on our voicemail and we will return your call. We do require **24-hours notice** if you are unable to keep your appointment. **Please read the Financial/Payment Policy section about "RESCHEDULED, CANCELED AND MISSED APPOINTMENTS"*

We look forward to meeting you and thank you again for choosing Marion Wellness for your health care needs.

1. **Treatment.** Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your friends or family members involved in your care.

2. **Payment.** Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as friends or family members. Also, we may use your PHI to bill you directly for services and items.

3. **Health Care Operations.** Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, to conduct cost management and business planning activities for our practice, or to train new healthcare workers.

4. **Treatment Options.** Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

5. **Release of Information to Family/Friends.** Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a guardian may ask that a neighbor take their parent or child to the physician's office for treatment. This neighbor may have access to this patient's medical information. We may also release information to friends or family members involved in your payment for health services we provide.

6. **Disclosures Required By Law.** Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

8. **Right to Provide an Authorization for Other Uses and Disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not covered by this notice or permitted by applicable law, such as for research or marketing. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any question regarding this notice or our health information privacy policies, please contact our Privacy Officer at (828) 652-8196.

This Notice of Privacy Practices is effective AUGUST 25, 2010.

MARION wellness &disease MANAGEMENT, PLLC

Kathleen McNutt
MSN, RN, ANP-BC
59 Gypsy Mountain Rd.
Marion, NC 28752
(828) 652-8196
www.marionwellness.com

MARION wellness &disease MANAGEMENT, PLLC

Notice of Privacy Practices

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

a. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of your PHI. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

How we may use and disclose your PHI
Your privacy rights in regard to your PHI
Our obligations concerning the use and disclosure of your PHI
How you can lodge a complaint about how we handle your PHI without your approval for certain matters

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our office in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Kathleen McNutt, MSN, RN, ANP-BC
Marion Wellness & Disease Management, PLLC
(828) 652-8196

C. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use your and disclose your PHI.

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