Directions to HAYWOOD THORACIC & VASCULAR:

581 Leroy George Dr. Suite 380; Clyde, NC 28721

Located on the third floor of the Haywood Regional Outpatient Care Center

From Waynesville/Sylva/Franklin:

- Take 19-23N to exit 105
- Turn Right at light (exit ramp) onto Hospital Dr
- At next light, turn left onto Jones Cove Rd.
- Take the 1st right onto Leroy George Drive toward Haywood Regional Outpatient Center
- Turn Right at stop sign, park in spaces to the right. We are located on the 3rd floor (Top), use entrance at covered walkway bridge.

From Asheville:

- Take I-40 to exit 27 onto 19-23.
- Take exit 105 (Jones Cove Road).
- Turn left at light.
- Stay straight through next stop light
- Take the 1st right onto Leroy George Dr. toward Haywood Regional Outpatient Center
- Turn right at stop sign, park in spaces to the right. We are located on the 3rd floor (Top), use entrance at covered walkway bridge.

Registration Form

Haywood
Thoracic and Vascular

Patient Information:

Last Name: _____ First Name: _____ MI: ___ Suffix: _____

SSN: _____-_____-____ Sex: (Circle) M F Birth Date: _____/_____/____

Mailing Address: _____ City: _____ State: ____ Zip: _____

Home Tel: _____-_____-_____ Cell Phone: _____-_____-_____ Work Phone: _____-_____-_____

Usual Doctor: _____ Primary Care Doctor: _____ Referring Doctor: _____

Advanced Directive: ☐ Y ☐ N Pharmacy Name/Phone Number: _____

Employer/School (Daycare): _____ Grade: _____ Email: _____

Skilled Nursing Facility: _____

Race:	Ethnicity:	Preferred Language:	Marital Status:
☐ White/Caucasian ☐ Black/African American	☐ Latino or Hispanic	☐ English	☐ Single ☐ Married
☐ Asian Hawaiian ☐ American Indian/Alaska Native	☐ Not Hispanic	☐ Spanish	☐ Divorced
☐ Pacific Islander ☐ More than 1 race	☐ Prefer not to answer	☐ Other	☐ Widowed
☐ Prefer not to answer			☐ Separated

Account Information: (Patient Information, Emergency Contact, Personal Representatives)

Please list any individuals (family, friends, etc) with whom we may discuss your medical care or leave.

Last Name, First Name Address City State Zip Home / Cell Phone Numbers Relationship

_____

_____

Please check all phones where we may leave voicemail regarding your care: ☐ Home ☐ Cell ☐ Work

Family Members Cared for in Practice: _____

Guardian/Guarantor Information: If minor, please list who the child lives with.

Last Name: _____ First Name: _____ MI: ___ Suffix: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Tel: _____-_____-_____ Cell Phone: _____-_____-_____ Work Phone: _____-_____-_____

SSN: _____-_____-____ Sex: ☐ M ☐ F Birth Date: _____/_____/____

Employer: _____ Relationship: _____ Email: _____

Policy Information: **Is this Workers Comp:** ☐ **Yes** ☐ **No**

Primary Insurance Company: _____

Policy Holder Full Name: _____ SSN: ____-____-____ Birth Date: _____/_____/____

Relationship to Patient: _____ Member ID: _____ Group ID: _____

Secondary Insurance Company: _____

Policy Holder Full Name: _____ SSN: ____-____-____ Birth Date: _____/_____/____

Relationship to Patient: _____ Member ID: _____ Group ID: _____

Please make sure that the receptionist copies your insurance card and drivers license

Prescriptions:

We ask that you bring a list of your medications with you at the time of each visit. If you need a refill, please call your pharmacy and ask them to fax a request. Our providers will review the request and refill by fax or notify you to make an appointment if necessary. We ask for up to 3 business days to refill all medications. Samples will only be given at scheduled appointments and are only authorized by the doctor.

_____ _____
Initial Date

Missed Appointment Dismissals:

Patients must notify this office 24 hours prior to your appointment if you need to reschedule or cancel. If you fail to notify the office within this time frame 3 times within a 1 year period, we have the right to dismiss you from the practice for noncompliance. If you do not show up for 3 appointments within a 1 year period, we have the right to dismiss you from the practice for noncompliance.

_____ _____
Initial Date

Haywood Thoracic and Vascular

581 Leroy George Drive, Ste 380, Clyde, NC 28721
Phone: 828-452-8970

Authorization for Release of Information

Name of Patient _____ Date of Birth_____

Haywood Thoracic and Vascular is authorized to releasee protected healh information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left of the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Appointment Reminders
☐ Spouse _____	☐ Financial ☐ Medical as follows: _____
☐ Parent(s)_____ _____	☐ Financial ☐ Medical as follows: _____
☐ Other _____ _____	☐ Financial ☐ Medical as follows: _____

Patient Information

I understand that I the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

X _____ Date_____

Signature of Patient or Personal Representative

Haywood Thoracic and Vascular

HIPAA ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information(PHI) about you. The Notice contains a Patient Rights section describing your rights under law. You have the right to review our Notice before signing this acknowledgement. The terms of our Notice may change; if we change our notice you may request a revised copy by contacting our office or you will receive a new notice the next time you are treated at our office.

You have the right to request that we restrict how we use protected health information about you for treatment, payment, and health care operations. We are not required to agree to this restriction if your request is not feasible or it impedes our ability to provide the treatment you need, but if we do accept your request, we shall honor that agreement.

The practice provides this from to comply with the Health Information Portability and Accountability Act of 1996. (HIPAA)

The patient understands that:

- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice
- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice reserves the right to change the notice of privacy practices.

I acknowledge receipt of the Notice of Privacy Practices.

_____
Printed Name of Patient or Representative

_____ _____
Signature Date

Relationship to Patient (if other than patient) _____

□Check if patient refused to take a copy of the Notice of Privacy Practices

State reason for refusal, if known:

Witness _____
Printed Name- Practice Representative

Witness _____ _____
Signature Date

Western Carolina Physician Practices

FINANCIAL POLICY

Thank you for choosing us as your health care provider. The following is our Financial Policy. Our main concern is you receive the proper and optimal treatment needed to restore and maintain your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask our staff.

1. Your insurance will be filed as a courtesy to you; however you are responsible for the entire bill. **All co-payments, unmet deductibles and other patient responsible services must be paid at the time of the visit.** If your insurance carrier applies the billed charges to your deductible, denies the services, or considers the services non-covered, you are responsible for payment of the service. **If you do not have insurance, payment in full will be expected at the time of the visit.**

2. In the event your insurance company does not pay the claim within a reasonable amount of time (45 – 60 days) then you may become responsible for the bill. If payment is not received within a reasonable amount of time from the guarantor, or if we receive returned mail as undeliverable, we will place your account with an outside collection agency.

3. If your insurance plan requires a referral or prior authorization, you must present this along with your insurance ID at each visit. If you do not have the referral when you arrive for your appointment, payment for the visit becomes your responsibility.

4. Returned checks will be subject to a returned check fee. A fee may be charged for missed appointments.

5. **PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUESTS:** I certify the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I request that payment of assignment benefits be made on my behalf.

6. **FINANCIAL AGREEMENT:** The undersigned in consideration of the services to be rendered to the patient is obligated to pay the medical practice in accordance with its regular rates and terms, and if the account is referred to an attorney or agency for collections, to pay reasonable attorney's fees and collection expenses. The undersigned hereby assigns to the medical practice all insurance benefits for services provided. The undersigned agrees to be responsible for charges not covered by insurance. It is understood the obligation to pay the practice may not be deferred for any reason, including pending legal actions against other parties to recover medical costs.

7. **CONSENT FOR ROUTINE TREATMENT** I hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my physician(s) at ____WCPP_____. I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician(s). I understand that my medical care may require the collection of samples, including fluids or tissues, from my body. This may include having blood drawn or tissues removed during tests, treatment, or surgery. Further, I understand that should any hospital or emergency medical personnel, physician, or other person(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including Hepatitis Band C as well as HIV/AIDS. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examination at_____WCPP_____. I have the right to refuse tests or treatment (as far as the law allows) and to be told what might happen if I do. I have the right not to have any photos or videos taken of me unless I agree to this, except as needed to treat me.

8. **ELECTION TO ELECTRONICALLY TRANSMIT MEDICAL INFORMATION AT DISCHARGE:** I authorize Hospital to provide a copy of the medical record of my treatment, the discharge summary, and a summary of care record to my primary care physician(s), specialty care physician(s), and/or any health care provider(s) or facility(ies) identified on my discharge paperwork to facilitate my treatment and continuity of care. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. The summary of care record consists of information from my medical record, including among other things, information concerning procedures and lab tests performed during this admission, my care plan, a list of my current and historical problems, and my current medication list. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take

back information that has already been released under this authorization. This authorization will expire automatically one year after the date on which my current treatment episode comes to an end.

9. **ADVANCE DIRECTIVE:** □ I have executed an Advance Directive □ I have not executed an Advance Directive

I have read and fully understand the Financial Policy and have been given the opportunity to ask questions.

_____ _____

Signature of patient, legal representative for health care services Date

If other than patient:

_____ _____

Relationship of Representative Reason individual is unable to sign, i.e. minor or legally incompetent

History & Physical

Haywood Thoracic & Vascular

Name: _____ **Date of Birth:** ___ /___ /___ **Today's Date:** ___ /___ /___

Today's Visit:

Age: _____ Height: _____ Weight: _____ Family Physician: _____

Chief Complaint: _____

Where on your body are you experiencing this? _____

What symptoms are you experiencing? _____

How long have you had these symptoms? _____

Have you ever had these symptoms before? _____

Are you here today due to an injury? ☐ Yes ☐ No

What is the estimated date of your injury/onset of pain? ___ / ___ / ___

How did you sustain your injury?

_____

On a scale of 1 - 10, what is your level of pain? (circle)

1 2 3 4 5 6 7 8 9 10
(No Pain) (Severe Pain)

Allergies:

Do you have any drug allergies? ☐ Yes ☐ No If yes, please list drug and reaction.

_____

_____

_____

Do you have any other allergies ☐ Yes ☐ No If yes, please list allergy and reaction.

_____

_____

_____

Medications

Please list all medications with dosage and strength, including over-the-counter meds/vitamins.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please briefly describe any other issues you would like to discuss today.

_____

_____

_____

_____

History & Physical

Haywood Thoracic & Vascular

Name: _____ **Date of Birth:** ___ /___ /___ **Today's Date:** ___ /___ /___

Medical History: Have you ever been diagnosed with any of the following?

- ☐ Allergies / Hay fever
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Arrhythmia
- ☐ Asthma
- ☐ Bleeding Problems
- ☐ Blood Clots
- ☐ Cancer (please specify) _____
- ☐ Chest pain / Angina
- ☐ Crohn's Disease
- ☐ Congenital heart disease
- ☐ Congestive heart failure
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Cough/Cold (recent)
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness / Fainting
- ☐ Epilepsy
- ☐ Fatigue
- ☐ GI Disorder
- ☐ Glaucoma
- ☐ Gout
- ☐ Headache
- ☐ Heart Attack / MI
- ☐ Heart murmur
- ☐ Heart palpitations
- ☐ Hepatitis-type Infection
- ☐ Hiatal Hernia
- ☐ High Blood Pressure
- ☐ HIV / AIDS
- ☐ Hyperlipidemia
- ☐ Incontinence
- ☐ Kidney Stones
- ☐ Liver disease
- ☐ Meningitis
- ☐ Menstrual dysfunction
- ☐ Osteoporosis
- ☐ Painful Breathing
- ☐ Parkinson's Disease
- ☐ Pneumonia
- ☐ Poor Circulation
- ☐ Psychological disorders
- ☐ Reflux
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Seizures
- ☐ Sexual dysfunction
- ☐ Shortness of breath
- ☐ STD
- ☐ Stroke / TIAs
- ☐ Thyroid Disease
- ☐ Ulcer
- ☐ Ulcerative Colitis
- ☐ Urinary issues

Surgical / Hospitalization History: Please list all, including minor procedures.

_____

_____

_____

_____

_____

Family History: Please indicate any family history of the following.

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Epilepsy/Convulsions	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐

History & Physical

Haywood Thoracic & Vascular

Name: _____ **Date of Birth:** ___ /___ /___ **Today's Date:** ___ /___ /___

Social History:

Do you smoke? ☐ Yes ☐ No

If Yes: How many packs daily? _____

How long have you smoked? _____

Interested in quitting? ☐ Yes ☐ No

Recently quit smoking? ☐ Yes ☐ No

Do you use any other form of tobacco?

☐ Yes ☐ No

Do you use drugs? ☐ Yes ☐ No

If Yes: What? _____

How often? _____

Do you consume alcohol ☐ Yes ☐ No

If Yes: How much? _____

Do you consume caffeine? ☐ Yes ☐ No

If Yes: How much? _____

Do you exercise? ☐ Yes ☐ No

If Yes: How much? _____

Do you have a history of domestic violence?

☐ Yes ☐ No

Do you have any difficulties sleeping?

☐ Yes ☐ No

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Do you have children? ☐ Yes ☐ No

Are you employed? ☐ Yes ☐ No If Yes: Where? _____