2905 Crouse Lane
Burlington, NC 27215
Phone: (336) 538-2494
Fax: (336) 538-2497

AllianceMedical ASSOCIATES

REGISTRATION

Today's date:	Primary Care Physician:

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital Status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name?	If not, what is your legal name?	(Former Name):	Birth Date:	Age:	Sex:
❑ Yes ❑ No			/ /		❑ M ❑ F

Street Address:	Social Security #:	Home Phone #:
	- -	( ) -

P.O. Box:	City:	State:	ZIP Code:

Pharmacy:	Pharmacy address & Pharmacy Phone #:	Patient Cell Phone #:
		( ) -

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.		❑ Insurance Plan	❑ Hospital
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Email Address:	

INSURANCE INFORMATION

(Please give insurance card to the receptionist)

Person responsible for bill:	Birth date:	Address (if different):	Home #:( )
	/ /		Cell #:( ) -

Is this person a patient here?	❑ Yes	❑ No		Insurance start date:

Occupation:	Employer:	Employer address:	Employer #:
			( ) -

Is this patient covered by insurance?	❑ Yes	❑ No	

Please indicate primary insurance	❑ Medicare	❑ Medicaid	❑ BCBS	❑ Medcost	❑ Tricare
❑ Aetna	❑ Cigna	❑ Wellpath	❑ United Healthcare	❑ Other	

Subscriber's name:	Subscriber's S.S. #:	Birth date:	Group #:	Policy #:	Co-payment:
		/ /			$

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

Name of secondary insurance (if applicable):	Subscriber's name:	Group #:	Policy #:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

PATIENT CARE

Do you have a living will or Power of Attorney for health care decisions? ❑ Yes ❑ No
Do you have a moral or religious reason for refusing a blood transfusion? ❑ Yes ❑ No
If **YES, do you have or need an informed refusal form?* ❑ Yes ❑ No

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone #:	Work phone #:
		( ) -	( ) -

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 Alliance Medical Associates, PLLC or insurance company to release any information required to process my claims.

Patient/Guardian signature	*Date*

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Patient: _____ Chart #: _____

****Release of Protected Health Information Form****

Alliance Medical Associates, PLLC takes the necessary steps to protect your. We understand that sometimes you are unable to call regarding your health information. If you would like to allow someone other than yourself to call and request this information, please complete the below section. There are a maximum of FIVE (5) people who can request your protected health information. A few examples of this type of information may include *appointment information*, *billing questions*, and *questions regarding your medical condition*. You also have the right to refuse anyone other than yourself to obtain this information (*other than for reasons of payment, treatment and healthcare operations as outlined in the privacy notice*.)

I authorize the following people to have access to my protected health information.

(*Please print*)

Name	Relationship to Patient

_____I do not want anyone, other than me, to have access to my protected health information.

_____ _____

PATIENT'S SIGNATURE **DATE**

Alliance Medical Associates, PLLC

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Patient Consent & Authorization Form

This notice describes how medical information about you may be used and disclosed and how you can get access to this information please read carefully.

We are committed to protecting the privacy of the information you provide to us regarding your health information under the (HIPPA) Health Insurance Portability and Accountability Act, effective April 14, 2003, I understand by signing this consent, I am authorizing the use and disclosure of my protected health information for:

- Treatment, diagnosing or providing treatment, sending or obtaining medical information from other health care providers involved in your treatment;
- Obtaining payment for your services provided, insurance companies, electronic claims filing or collection agencies; and
- For daily health care operations of our practice.

There are several circumstances where the use and disclosure of your medical information is legal without your consent, complete details are in our notice of privacy, a copy of which is available to you in our waiting room, a copy of which is available to you in our waiting room. Any other uses and disclosures of your medical information will be made only with your written request. We are required to make available for your review or give a copy of our notice of privacy practices, which contains a more detailed description of the uses and disclosures of your protected health information and your rights under HIPPA. We are required to abide by the terms of our notice of privacy practices. We reserve the right to change the terms of our notice at any time and you may obtain the most current copy of this notice.

You have the right to request restrictions on how your protected health information is used and disclosed. You may also revoke this consent at any time. Any restriction, revocation or complaint of your protected health information may be done in writing to our privacy officer, Sonia Sweat. However, any use or disclosure that occurred prior to the date of this consent is not affected.

I hereby authorize Alliance Medical Associates, PLLC to furnish information to my insurance carriers concerning my illness and treatment, and I assign Alliance Medical Associates, PLLC payment for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by the insurance company.

_____ _____

Patient Signature **Date**

Alliance Medical Associates, PLLC

FINANCIAL POLICY

Our financial policy is to advise of fees relating to the collection of payments from our patients and/or their insurance company. These policies are as follows:

1. All co-pays or coinsurance are due at the time of service. You will be asked to reschedule your appointment if you do not pay your co-pay unless you are having a life threatening issue or if you make financial arrangements with our Billing Department prior to your appointment. If the insurance does not pay due to the termination of the patient's policy or if there is an outstanding balance due to a deductible, the patient is responsible for the balance. Payment in full is required if Alliance Medical Associates, PLLC does not participate with your insurance and you will be responsible to get reimbursed from your insurance company. Our office does not bill for liability cases. We will provide a statement to you to forward after payment is made in full. For our patients who are Self-Pay, payment in full is required at the time of service. Prior arrangements MUST be made with our Billing Department if payment in full cannot be made at the time of service.

2. Allowable forms of payment are cash, check, money order, and American Express, MasterCard, Discover, Visa, or CareCredit. A returned check for non-sufficient funds will result in a $25.00 fee in addition to the amount of the check.

3. Monthly statements are sent for balances due after the insurance has processed your claim. If a monthly payment is not made on your account, after 90 days, the account will be sent to our collection agency and an additional 35% of the balance will be assessed to you as well as any legal fees that we incur.

4. Patients who miss regularly scheduled office visits without a **24-hour notice** will receive a No-Show warning letter. Subsequent missed appointments will result in a $25.00 fee. Four missed appointments will result in termination from our practice. *Any other procedures and/or test may result in additional charges.

5. Patients who are referred to our office by another doctor must bring a referral for the services if their insurance requires one. Failure to get a referral can result in a rescheduled appointment.

6. Patients who request their records be transferred out of our office must sign a transfer request. Our fee for transferring records is $.75/page. Any unpaid balance at the time of transferring records should be paid or it will be sent to our collections agency.

7. A charge of $20.00 for all non-billable letters / forms (i.e.: FMLA, Disability, Life Insurance) must be paid at the time of drop off. When these forms are finished, a staff member will call you to pick up the forms.

I have read and understand the above financial policy.

_____ _____

(Patient Signature) (Date)

_____ _____

(Representative of Alliance Medical Associates, PLLC) (Date)

Revised 04/26/2013

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Insurance Assignment

♦ WAIVER OF LIABILITY

I hereby authorize Alliance Medical Associates, PLLC, to furnish information to my insurance carriers concerning my illness and treatment. I assign, Alliance Medical Associates, PLLC, payment for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by the insurance company.

I understand that if I fail to provide Alliance Medical Associates, PLLC my current and correct insurance card(s), I am liable for any and all charges that are incurred.

_____ _____

Patient Signature **Date**

♦ CONSENT TO TREAT

I hereby authorize medical treatment of myself/minor by Alliance Medical Associates, PLLC. I am aware that the practices of medicine are not an exact science and acknowledge that no guarantees have been made concerning my care.

_____ _____

Patient Signature **Date**

PATIENT ACKNOWLEDGMENT AND CONSENT

For New Patients Only

I have been given a copy of Alliance Medical Associates, PLLC Notice of Privacy Practices, version effective 01/30/2019. I consent to the uses and disclosures of my health information as outlined in the Notice.

_____ _____

Signature of Patient or Representative Date

_____

Print Name

_____

Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of Patient: _____

_____

_____

FOR Alliance Medical Associates, PLLC USE ONLY

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain acknowledgment and the reason you could not obtain it:

_____

_____

_____

_____

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AUTHORIZATION FORM

I AUTHORIZE ALLIANCE MEDICAL ASSOCIATES TO OBTAIN OR DISCLOSE PRIVATE HEALTH INFORMATION TO/FROM

me of person or facility: _____

Address: _____Phone or Fax: _____

The protected health information of

Patient name: _____DOB: _____SS# (last 4 digits) _____

Address: _____Dates of Service(s): _____

Put a check mark next to the specific documents that apply to your request:

Clinic notes___ Operative/Procedure notes___ Progress Notes___ Emergency Dept. notes___

Provider orders___ Radiology reports___ Urgent Care center notes___ Nursing notes___

Patient Billing records___ History and Physical___ Consultations___ Films/CD (Imaging support) ___

Discharge Summary___ Laboratory reports___

I understand that the information released may include sensitive information related to behavior and/or mental health, drugs and alcohol (including records of a program that provides alcohol or drug abuse diagnosis, treatment, or referral, as defined by federal law at 42 C.F.R. part 2), HIV/Aids and other communicable disease, and genetic testing. This authorization does not include permission to release psychotherapy notes (defined as records from private, joint, group, or family counseling session that are separated from the rest of the patients medical records). Release of psychotherapy notes requires a separate authorization.

Please put a check mark next to the purpose of this request:

Attorney/Legal___ Continued Patient care___ Insurance___ Personal use___ Social Services/ Disability: ___ Other: ___

I understand that:

I may revoke this authorization at any time. The revocation will not apply to information that has already been release in response to this authorization. I must revoke this authorization in writing. The procedure for revoking this authorization is to present my written revocation to Alliance Medical Associates. A fee will be charged to the patient when patient is requesting medical records to be released to the patient (.75 per page)

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 possible that once disclosed, the privacy of the information may no longer be protected under federal medical privacy law.

Unless otherwise revoked this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date or event or condition, this authorization will expire automatically in 90 days from the date of signature.

I have read and understand the information is this Authorization form:

Signature of Patient: _____ Date: _____

Print Name: _____

Signature of Authorized Representative: _____Date:_____

Printed Name: _____

AllianceMedical ASSOCIATES
Care. Dedication. Excellence.

commonwell HEALTH ALLIANCE

Dear Patient,

We believe that patients and your caregivers should have easy access to your medical information, no matter where you receive care. That's why we're participating in CommonWell, a service that allows a network of healthcare providers to identify you, securely send and receive your medical information, and help ensure that you receive optimal care.

What is CommonWell?

A *free, secure service* offered by your doctor, so your health information can be available to you and your doctors regardless of where you've received care.

You simply need to enroll in the service with a driver's license and then confirm the other CommonWell network doctors you see. Don't worry if you don't have a government-issued picture ID, you can still register.

How do we use the health information we share through CommonWell?

- ***Better coordinate your care across different doctors*** — We'll provide and request to receive your information *where* and *when* it's needed for your healthcare provider to deliver the care you need as you move from doctor to doctor.
    - Only healthcare staff directly involved in your care will access your medical information shared through CommonWell.
- ***Support better care decision-making*** — With timely access to information from other healthcare providers you've seen, your doctors may be able to make better decisions about your health.
    - This information will only be used to help improve your care; and won't be shared without your permission or unless it's required by law.
- ***Deliver care more promptly and efficiently*** — With less time wasted on tracking down your test results and other health information, your healthcare providers can treat you more efficiently, and spend less time on paperwork and more time on your care.
    - We do need your help in confirming the other doctors or hospitals you've visited when you enroll in CommonWell.
- ***Securely and confidentially*** — Your Protected Health Information ("PHI") will always be confidential and used to inform the CommonWell participating healthcare providers. We won't use your PHI for discriminatory purposes of any kind or to deny medical treatment.
    - You can opt-out of this service anytime by calling or visiting this doctor's office and asking them to unenroll you from CommonWell.

How do I sign up?

It's quick and easy. Show the staff at the front desk or during patient discharge your government-issued ID (driver's license, etc.) and tell them what other doctors, hospitals and healthcare providers you've seen.

Patient Signature _____

CommonWell Health Alliance

The CommonWell services are provided by the CommonWell Health Alliance trade association. We are devoted to the notion that patient data should be safely, securely and immediately available to patients and doctors regardless of where care occurs to deliver better care. We are committed to fostering standards that make this possible, and in having health information technology companies build these capabilities into their systems. The end results: higher quality, more timely, more cost-effective care that delivers better health outcomes. Participating vendors are: Allscripts, athenahealth, Cerner, CPSI, Greenway, McKesson, and Sunquest.

Name: _____ DOB: _____

E-mail:_____

Welcome to Alliance Medical Associates, we are innovative multi-specialty practice located in Burlington, North Carolina. At Alliance Medical Associates we strive to offer our patients convenient, high-quality care. One of the ways we do this is by offering our patients online health services through our website. These services include appointment scheduling, access to medical records, medication renewals, and more. You will be given instructions on how to proceed online. Please update your email address with us. Your e-mail will be kept private and secure (not to be sold or released to any other source). Thank you!

Name: _____ DOB: _____

E-mail:_____

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