Welcome to Meridian

The following pages comprise the new patient information packet Meridian Medical Group gives to all new patients. Most of these pages will become part of your patient chart. This cover page serves as a checklist reminder of what each page represents, and how to use each.

ALL PATIENTS SHOULD COMPLETE THESE FORMS:

Patient Information Sheet

The Patient Information Sheet serves as a hard-copy version of basic demographic information on a patient (name, address, phone number) as well as information for our billing staff to use if you plan on allowing us to bill your insurance company directly. Please complete this form and present it to our staff at your first visit.

Patient History Sheets (both adult and pediatric are provided - 2 pages each)

The Patient History Sheets allow the doctor to learn more about the patient's Past Medical History, Family History, medications, allergies, and other medically relevant information that pertains to the patient. Please complete the appropriate sheets and present them to our staff at your first visit.

Clinic Policies (Each clinic has their own: 2 for the Randolph Office and 2 for the South Office)

The Clinic Policies pages are included in this document as a reference for you to keep. It helps you to understand how we conduct our practice, and what we expect of our patients.

Financial Policies (Only the Randolph Office uses this form)

If you plan to have your care delivered from the Randolph Office, please read and sign this form.

Patients with Commercial Health Insurance Notice

This page explains that sometimes commercial health insurance plans do not cover certain services. This page should be signed, dated, and turned in with your new patient paperwork.

OPTIONAL FORMS NOT INCLUDED IN THIS FILE

Release of Medical Information Sheet

Many patients have previous medical records at other offices that they have accumulated over the time they have been with that practice. As a continuation of care, it is generally recommended that these records be transferred into our clinic so we may use them in continuing care. If you need this form, please return to our web site and download the "Release of Medical Information Sheet" file and print as many copies as needed.

Randolph Office:	**South Office:**	**University Office:**
1918 Randolph Dr., Suite 275 Charlotte, NC 28207 Phone: (704) 384-1354 Fax: (704) 384-1374	11030 Golf Links Drive, Suite 100 Charlotte, NC 28277 Phone: (704) 384-1166 Fax: (704) 384-1181	8420 Univ. Exec. Park Dr., Suite 850 Charlotte, NC 28262 Phone: (704) 316-1750 Fax: (704) 316-1755

Patient Information / Consent to Treatment

PATIENT INFORMATION	Account #:	Medical Record #:	Date:
Patient Name:		Referring Doctor:	
Address:		Referring Doctor Phone #:	
City/State/Zip:		Primary Doctor:	
Home Phone:	Work Phone:	Employer/School:	
SS #:	DOB:	Age:	Marital Status:	Sex:
Emergency Contact:	Relationship:	Phone #:	
Responsible Party:	Relationship:	DOB:	SS #:
Responsible Party Address:		City/State/Zip:	Phone #:
INSURANCE INFORMATION			
Primary Insurance:	Employer:	Secondary Insurance:	Employer:
Insurance ID #:	Insurance Group #:	Insurance ID #:	Insurance Group #:
Insured's Name:		Insured's Name:	
Address:		Address:	
City/State/Zip:		City/State/Zip:	
Insured's DOB:	Insured's SS #:	Insured's DOB:	Insured's SS #:

Financial Responsibility and Assignment of Insurance Benefits:
I guarantee payment to Novant Health and it affiliates (Novant Health) of all charges for services provided to the patient. I understand I am personally responsible for all charges not covered by insurance. I authorize payment of surgical and medical benefits, which would otherwise be payable to me, to Novant Health for services rendered. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment under Titles V, XVIII and/or XIX of the Social Security Act is correct.

Consent for Healthcare and Release of Medical Information:
I voluntarily consent to healthcare treatment ('Treatment') from the physicians and staff at this Novant Facility. I am aware that the practice of medicine is not an exact science. No guarantees have been made to me regarding the result of treatments or examinations by my caregivers. I consent to the use and disclosure of protected health information about me for treatment, payment and healthcare operations. I have read this form. I have had the opportunity to ask questions and my questions have been answered.

Would you like information on advance directives? Y _____ N _____
(Living Will, Health Care Power of Attorney, Advance Instruction for Mental Health Treatment, Organ Donation)

Signature of Patient or Authorized Person: ___________________________________ **Date** _______________

Insured Party or Financial Guarantor, if different from above: ______________________________ **Date** _____________

Acknowledgment of Receipt of Joint Notice of Privacy Practices:
I have received a copy of the Novant Health Joint Notice of Privacy Practices. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice on Novant Health's website at www.novanthealth.org, by writing to the Privacy Officer, PO Box 33549, Charlotte NC 28233, or by requesting one at any Novant Health provider location.

Signature of Patient or Authorized Person: ____ **Date** _____________

For Staff Use Only
__Patient refused to sign after he/she received Joint Notice of Privacy Practices and was informed that signing the form merely acknowledges that the patient actually received the notice.
__Patient was initially treated for an emergency condition. Patient either was given the notice after stabilization or will be given the notice after transfer **(Circle One)**

If Limited English proficiency or hearing impaired:
__Interpreter offered. Name of person or service used ____ ___ Interpreter Refused

Signature of Staff: ____ **Date** _____________

ADULT
PATIENT HISTORY

Date ___________________

Name ____ Date of birth ______________________ Sex M ___ F ___

Occupation ____ Marital Status Single _______ Married ________
Divorced _____ Widowed _______

Race ______________________________ Age _____________

PAST MEDICAL HISTORY Have you ever had any of the following (Circle)

High Blood Pressure
Heart Attack/ Angina
Heart Murmur
Crohn's Disease
Rheumatic Fever
Pneumonia
Emphysema
Prostate Trouble
HIV disease
Asthma
Tuberculosis
Phlebitis
Bleeding Disorder
Sickle Cell Anemia
Blood Transfusion
Gallstones
High Cholesterol
Hepatitis
Kidney Disease/ Stone
Stomach Ulcers
Diabetes
Thyroid Disease
Cancer
Sexually Transmitted Disease
Arthritis
Stroke
Migraine Headaches
Seizures
Anxiety
Glaucoma
Cataracts
Depression
Trouble Achieving and/or maintaining an erection

Other serious illnesses: ____

OPERATIONS (Give date or age)

Tonsils _________________ Gallbladder ______________ Kidney ____________________ Biopsy _________________
Appendix ________________ Stomach ________________ Hysterectomy _____________ Prostate ________
Hernia _________________ Heart __________________ Ovaries Removed __________ Breast __________________
Other ____ Tubal Ligation __________

OTHER HOSPITALIZATIONS/ ACCIDENTS/ INJURIES ______________________________

____

____

FAMILY HISTORY

	Age	Alive	Deceased	Health Problems
Father				
Mother				
Sister				
Sister				
Brother				
Brother				
Children				

IMMUNIZATIONS (Approximate date or age) PPD __________

Flu _____________ Pneumonia _____________ Tetanus __________ Hepatitis ___________

ADULT
PATIENT HISTORY
PAGE 2

FOR WOMEN

Age at first period __________ Date of last period ________________ Age at menopause ______________
Regular Periods? Yes ____ No ____ Interval between periods ___________ Length of periods _________________
# of Pregnancies ________ Live Births _________ Miscarriages _________ Abortions ______ Stillbirths _
Birth Control Method _______________________ Doing monthly self breast exam? _________________________

ALLERGIES (Medication, Foods, Pollens, etc.)

____

____

CURRENT MEDICAL OR PSYCHOLOGICAL PROBLEMS

List all conditions currently being treated: Name of Physician:

____ ____

____ ____

CURRENT MEDICATIONS

(List name, dosage, times per day. Include nonprescription drugs, vitamins, laxatives, herbs, etc.)

1. ____ 4. ____
2. ____ 5. ____
3. ____ 6. ____

HABITS Do you:

	Yes	No	Amount/ Type
Use drugs (marijuana, cocaine)			
Use tobacco (cigarettes, cigars, chewing tobacco)			
Use alcohol (beer, wine, liquor)			
Use caffeine (coffee, tea, colas)			
Diet (restrictions, special diet)			
Exercise regularly			
Wear seat belts?			

WHEN DID YOU LAST HAVE THESE PERFORMED?

Prostate Exam _________________ Breast Exam ___________ Rectal Exam __________________
EKG ________________________ Mammogram __________ Stool Test for Blood ____________
Cholesterol ___________________ Pap Smear ____________ Colon Scope Test ______________
Have you ever been: on disability? ____
Denied life or health insurance? ____
Have you had a significant weight change in the last year? ____
Do you have a living will or advance directive? ________________________ If not, are you interested in information about this? _____________

WHAT ARE THE MOST IMPORTANT MEDICAL PROBLEMS YOU HAVE NOW?

____

____

PEDIATRIC PATIENT HISTORY

Today's Date ___________

Child's Name _____________________________________ Birthdate ____________ Sex: Male Female
Mother ____ Birthdate ____________
Address ____ Phone ______________
Father ____ Birthdate ____________
Address ____ Phone ______________
Legal guardian (if other than parent) ____ Phone ______________
Address ____
Siblings (names and birthdates)
____
____
Parents are: married ___ single ___ separate ___ divorced ___
Members of household ____
____
Pets in the home ______________________ Smokers in the home ____________________
Water fluoridated? yes ___ no ___ Diet ____
Does child attend daycare? _______________ Comments ____________________________________

ALLERGIES (please list) ____

BIRTH HISTORY
Length of pregnancy ________________________________ Type of delivery: vaginal _______ C-section ______
Weight _______ Length _______________ Apgar scores _________ / _________
Type of feeding breast ____ formula (name) ____
Complications during pregnancy, labor or delivery ____
Problems in nursery ____

DEVELOPMENT At what age did the child first:
Roll over _____________________________ Sit alone ____________________ Speak single words ___________
Crawl ________________________________ Walk alone __________________ Make sentences ______________
Toilet train ___________________________

Did the child have any of the following problems during the first few months of life? (circle if yes)

jaundice	anemia	breathing difficulty
trouble feeding	seizures	blue spells
severe colic	infections	required oxygen

CHILDHOOD ILLNESSES Has the child had any of the following? (circle if yes)

chicken pox	meningitis	tubes in ears	pneumonia
asthma/wheezing	seizure	heart murmur	frequent ear infections

Other chronic or ongoing medical problems ____
____

HOSPITALIZATIONS (for surgery, accidents, or injuries). List date and reason for hospitalization

____

____

PEDIATRIC PATIENT HISTORY
PAGE 2

MEDICATIONS List all. Including vitamins, fluoride, iron, prescription, and non-prescription drugs.

____

____

FAMILY HISTORY Do any of the child's close relatives (parents, grandparents, brothers, or sisters) have any of the following? (circle if yes)

High blood pressure	Diabetes	Allergic disease	Seizures
Heart disease	Bleeding disorders	Asthma	Kidney disease
Sickle cell	Cystic fibrosis	Alcoholism	High cholesterol
Cancer	Mental problems		

IMMUNIZATIONS **Please provide us with a current list of all immunizations received.**

DOES THE CHILD HAVE ANY UNUSUAL PROBLEMS WITH (circle if yes)

behavior	temper tantrums	nightmares	trouble in school
discipline	vision	bedwetting	learning difficulty
breath holding	speech	toilet training	attention deficit
hyperactivity	thumb sucking		

WHAT RECENT PROBLEMS HAS THE CHILD HAD? ________________________________

____

WHAT CONCERNS DO YOU HAVE TODAY?

____

____

____

____

____

____

CLINIC POLICIES-RANDOLPH

Welcome to Meridian Medical Group. The following Clinic Policies are designed to make your visit to our clinic as pleasant and efficient as possible.

Appointment & Scheduling

When calling to schedule an appointment, dial 704-384-1354 and press 1

Insurance Cards

We will require a copy of your insurance card(s) every time you are seen in our office. We are unable to process your claim without it; and if you cannot provide proof of insurance coverage at time of service, you will be treated as a self-pay patient.

Be On Time For Your Appointment

As your health care provider, we have an obligation to treat you. As a patient, you have an obligation to be on time for your appointments.

New Patients & Physicals: Please arrive **30 minutes early** to complete your registration.

Established Patients: Plan on arriving **15 minutes early** to complete any necessary paperwork and to allow for verification of insurance.

Sick Visits: If you are late for a sick visit, we will always see you or make arrangements for you to be seen. We have an obligation to other patients, so you may have to wait for an opening in the schedule or until the end of the day.

Medications

Patients must **bring all medications**, including herbal medications, to every appointment.

Prescription Refills

Your doctor should give you a prescription to cover the length of time until he/she wants to see you again. Should you need a prescription refilled before your next visit, **please call you pharmacy.** Refills of prescriptions can take from 48-72 hours to process, so allow plenty of time for us to refill your medication before you run out. Also, be aware that **our night and weekend on-call physicians are not able to refill your medications.**

Yearly Physicals

Please check your insurance policy carefully before scheduling a physical exam. Most insurance carriers require a minimum 1 year interval between physical exams, but some require 3 years. Should you violate this requirement, you will be 100% responsible for all charges. Medicare patients, remember that Medicare will not pay for preventative services such as physicals.

PLEASE TURN PAGE OVER ⇒

CLINIC POLICIES (RANDOLPH) - CONTINUED

Referrals

If your insurance plan requires you to have a referral to see a specialist, please schedule a visit with your doctor. He/She will complete a Referral Form and send it for processing. It will take between 5-7 work days to process your referral. You will receive a copy in the mail; at which time, you can call to make an appointment with the specialist. **Do not call the Specialist prior to receiving your Referral Form in the mail.**

If your insurance plan does not require a referral, you may contact the Specialist office directly without authorization from your primary care physician.

Laboratory

If you are required to have laboratory work done at your doctor's request, the **Hours of Operation are: 8:15am - 12:30pm and 2:15pm - 4:30pm Monday - Friday.**

We will not do laboratory work for outside providers.

Physical Forms and Immunization Records Requests

Bring all physical forms and immunization records requests to your appointment. Forms will be completed during your visit at no charge.

There is a fee to process any forms or requests not presented during an office visit. Please allow 5-7 business days to process these requests.

Minor Patient Visits

Under most circumstances we cannot see a minor without an accompanying parent, guardian, or adult with written consent from the parent or legal guardian. The adult accompanying the minor, and the parents or guardian, are responsible for any patient balances due at the time of service.

Telephone Messages

A high volume of telephone calls is received every day. We will make every effort to return calls as soon as our schedule allows. If you do call, please leave a telephone number where you can be reached during business hours. Thank you, and **please be patient.**

Medical Records Copies

We are legally bound to protect the confidentiality of your medical record, so nothing can be released without a signed release form. Meridian has contracted with a company which specializes in copying medical records. **They have a nominal charge.** It takes 5 - 10 working days to process your request.

Cellular Telephones

Please refrain from cell phone use while our staff is assisting you.

CLINIC POLICIES-SOUTH

Welcome to Meridian Medical Group. The following Clinic Policies are designed to make your visit to our clinic as pleasant and efficient as possible.

Appointment & Scheduling

When calling to schedule an appointment, dial 704-384-1166 and press 0

Insurance Cards

We will require a copy of your insurance card(s) every time you are seen in our office. We are unable to process your claim without it; and if you cannot provide proof of insurance coverage at time of service, you will be treated as a self-pay patient.

Be On Time For Your Appointment

As your health care provider, we have an obligation to treat you. As a patient, you have an obligation to be on time for your appointments.

New Patients & Physicals: Please arrive **30 minutes early** to complete your registration.

Established Patients: Plan on arriving **15 minutes early** to complete any necessary paperwork and to allow for verification of insurance.

Sick Visits: If you are late for a sick visit, we will always see you or make arrangements for you to be seen. We have an obligation to other patients, so you may have to wait for an opening in the schedule or until the end of the day.

Medications

Patients must **bring all medications**, including herbal medications, to every appointment.

Prescription Refills

Your doctor should give you a prescription to cover the length of time until he/she wants to see you again. Should you need a prescription refilled before your next visit, **please call you pharmacy.** Refills of prescriptions can take from 48-72 hours to process, so allow plenty of time for us to refill your medication before you run out. Also, be aware that **our night and weekend on-call physicians are not able to refill your medications.**

Yearly Physicals

Please check your insurance policy carefully before scheduling a physical exam. Most insurance carriers require a minimum 1 year interval between physical exams, but some require 3 years. Should you violate this requirement, you will be 100% responsible for all charges. Medicare patients, remember that Medicare will not pay for preventative services such as physicals.

PLEASE TURN PAGE OVER ⇒

CLINIC POLICIES (SOUTH) - CONTINUED

Referrals

If your insurance plan requires you to have a referral to see a specialist, please schedule a visit with your doctor. He/She will complete a Referral Form and send it for processing. It will take between 5-7 work days to process your referral. You will receive a copy in the mail; at which time, you can call to make an appointment with the specialist. **Do not call the Specialist prior to receiving your Referral Form in the mail.**

If your insurance plan does not require a referral, you may contact the Specialist office directly without authorization from your primary care physician.

Laboratory

If you are required to have laboratory work done at your doctor's request, the **Hours of Operation are: 8:15am - 12:30pm and 1:30pm - 5:00pm Monday - Friday.**

We will not do laboratory work for outside providers.

Physical Forms and Immunization Records Requests

Bring all physical forms and immunization records requests to your appointment. Forms will be completed during your visit at no charge.

There is a fee to process any forms or requests not presented during an office visit. Please allow 5-7 business days to process these requests.

Minor Patient Visits

Under most circumstances we cannot see a minor without an accompanying parent, guardian, or adult with written consent from the parent or legal guardian. The adult accompanying the minor, and the parents or guardian, are responsible for any patient balances due at the time of service.

Telephone Messages

A high volume of telephone calls is received every day. We will make every effort to return calls as soon as our schedule allows. If you do call, please leave a telephone number where you can be reached during business hours. Thank you, and **please be patient.**

Medical Records Copies

We are legally bound to protect the confidentiality of your medical record, so nothing can be released without a signed release form. Meridian has contracted with a company which specializes in copying medical records. **They have a nominal charge.** It takes 5 - 10 working days to process your request.

Cellular Telephones

Please refrain from cell phone use while our staff is assisting you.

FINANCIAL POLICIES - RANDOLPH

Thank you for choosing Meridian Medical Group as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy:

All patients must complete our Information and Insurance Form before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT: Cash, Checks, And Credit Cards, except American Express & Discover

Regarding Insurance

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 45 days, the balance may automatically become your responsibility. Please be aware that some, and perhaps all, of the services provided may be non-covered services under you plan and you will be 100% responsible for these charges.

Regarding Insurance Plans where we are a participating provider, all co-pays and deductibles are due at time of treatment. In the event that your insurance coverage changes to a plan where we are not a participating provider, you will be 100% responsible for all charges incurred.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You may be responsible for payment regardless of any non-contracted insurance company's arbitrary determination of usual and customary rates.

Adult Patients

Adult patients are responsible for full payment at time of service.

Minor Patients

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for any patient due balances at time of service. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/MasterCard, or payment by cash or check at time of service has been verified.

Missed Appointments

Unless canceled at least 24 hours in advance, our policy is to charge $25.00 for missed appointments. Insurance plans will not pay for this charge, so please help us serve you better by keeping scheduled appointments.

After-Hours Triage Services

Should you require medical assistance during non-business hours, simply call your doctor's office. You will be transferred to our answering service that will have a Triage nurse contact you to answer your healthcare questions or arrange for appropriate medical care to meet your needs. Please note, there may be a $10 charge for a non-urgent telephone consultation.

Please remember, you cannot schedule a weekday appointment or request a prescription refill using the After Hours telephone service.

Thank you for understanding our Financial Policy. Please let us know if you have any questions.

I have read and agree to this Financial Policy:

X ____ **Date** ______________________

Signature of Patient or Responsible Party

Presbyterian
REGIONAL HEALTHCARE CORP

ADVANCED NOTICE

Patients with Commercial Health Insurance (Managed Care Plans)

Some examples of managed care plans include Health Maintenance Organizations (HMO), Point of Service (POS) Plans, and Preferred Provider Organizations (PPO). They will only pay for healthcare services that are determined to be medically needed and are considered "covered services." Covered services are defined in the managed care plan's certificate of coverage or group medical agreement. Every enrolled member is given a copy of these documents. If a managed care plan determines that a service is not medically necessary or is not covered, as defined in its certificate of coverage, then the managed care plan will not pay for the service.

In certain cases, your provider, based on his or her medical opinion, may request that a service and/or test be performed that may not be considered a covered service as defined in your certificate of coverage. Services that a provider may request that may not be considered "covered services" may include, but are not limited to:

- Periodic physical examinations;
- Certain screening or diagnostic tests;
- Certain immunization;
- Flexible sigmoidoscopies;
- Skin biopsies;
- School, sport, or work physicals;
- DEXA bone mass measurements; and/or
- Other special procedures.

If you have a question or concern about a procedure that may not be covered by your insurance company, we encourage you to contact your insurance company directly.

I understand my managed care plan may not pay for these services. I will receive a statement from my provider's office for any non-covered services. I agree to be personally and fully responsible for timely payment of the amount billed.

____
Patient Name (please print)

____
Patient / Authorized Signature Date

Limited English proficiency or hearing impaired:

Interpreter Offered _______________ Name / Number of Person / Services Used Interpreter Refused

* Please attach -GA Modifier to service