NorthEast Plastic & Reconstructive Surgery

Today's Date:_____/_____/_____

Name: _____

DOB: _____/_____/_____ **Sex:** ☐ Female ☐Male

Marital Status (*mark one*): ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐Widowed

SS#: _____-_____-_____

Race: ☐ African American ☐ Caucasian ☐ Haw/Pac Isl/Hisp ☐ Other_____

Address: _____

City, State: _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

Employer: _____**Work Phone:** _____

Employment Status:
☐ Full Time | ☐ Self Employed | ☐ Student | ☐ Retired
☐ Part Time | ☐ Unemployed | ☐ Disabled | ☐ Other: _____

Referring Physician: _____ **Primary Physician:** _____

Name of Insurance Company: _____

Guarantor Name: _____ **Relationship:** _____

Home Phone: _____ **Cell Phone:** _____

Employer: _____**Work Phone:** _____

☐ Full Time ☐ Part Time ☐ Other: _____

SS#:_____-_____-_____ **DOB:** _____/_____/_____ Sex: ☐ Female ☐Male

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1st Emergency Contact: _____ **Relationship:** _____

Home Phone: _____ **Cell Phone:** _____

2nd Emergency Contact: _____ **Relationship:** _____

Home Phone: _____ **Cell Phone:** _____

200 Medical Park Drive, Suite 320 • Concord, North Carolina 28025 • 704-403-2760 • 704-403-2779 (fax)

Patient Information: I give permission to release the health information of: **(One Patient Per Form)**

Patient Name: _____ Date of Birth: _____

Street Address: _____ Last 4 numbers of SSN: _____

City, State, Zip: _____ Telephone: ( ) _____

Email address: _____

By providing your email address you acknowledge and accept the risks outlined in the Guidelines for E-mail with Patients, posted on carolinashealthcare.org.

Release Information From:

_____

(List applicable Facility(s) and/or Practice(s)

_____

_____

(Phone number) (Fax number)

Release Information To:

_____

(Name of facility, person, company)

_____

(Street Address or PO Box, City, State, Zip Code)

_____

(Phone number) (Fax number)

PURPOSE OF RELEASE (check reason): ☐ Request of individual/personal ☐ Continued patient care ☐ Insurance
☐ Legal purpose including discussions & proceedings ☐ Other _____

Fill in dates of treatment for records to be released:

Treatment dates: From _____ **To** _____

Facility Summary: May include history & physical, discharge summary, operative notes, consults, diagnostic test results, medication list, allergies.
Office/Clinical Summary: May include most recent office visits, physical exam, consults, diagnostic test results.

Facility (check all that may apply):
☐ Facility Summary
☐ Discharge Summary ☐ Emergency Record
☐ History and Physical ☐ Cardiac Reports/EKG
☐ Consultation reports ☐ Other _____
☐ Operative Reports _____
☐ Laboratory reports _____
☐ Radiology/X-Ray Reports _____
☐ Pathology reports _____

☐ Entire record (Not including psychotherapy notes)
☐ Itemized Bill

Office/Clinic/Home Care (check all that may apply):
☐ Office/Clinical Summary
☐ Office/Home Visits
☐ Physical Exam
☐ Laboratory Reports
☐ Radiology Reports
☐ Other _____
_____

☐ Entire Record (Not including psychotherapy notes)
☐ Itemized Bill

Behavioral Health/Sub. Use (check all that may apply):
☐ Facility Summary
☐ Clinical/Discharge Summary
☐ Assessments
☐ Physician Orders
☐ Progress/Therapy Notes
☐ Medications
☐ Lab reports
☐ Other _____

☐ Entire Record (Not including psychotherapy notes)
☐ Itemized Bill

FORMAT:
☐ CD (charges may apply)
☐ Email Address noted above, where permitted
☐ Paper copy (charges may apply)
☐ Other _____

DELIVERY METHOD:
☐ Reg.US Mail ☐ Pick-up ☐ Fax, where permitted
☐ Overnight/Express Mail Service, where permitted
☐ Secure email
☐ Other: _____

PATIENT'S RIGHTS – I understand that:

- **I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice.**
- **This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases.**
- **Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.**
- **Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in health plan, or eligibility for benefits.**
- **Atrium Health will not share or use my health information without my permission other than by ways listed in Atrium Health's Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at carolinashealthcare.org.**
- **A fee may be charged for providing the protected health information.**

This permission expires one year after the date of my signature unless another date or event is written here: _____

Signature: _____ **Print Name:** _____ **Date:** _____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form.
Note the relationship/authority if signature is not that of the patient (Written Proof May be Requested):
☐ Healthcare Agent/POA ☐ Guardian ☐ Executor/Administrator/Attorney in Fact ☐ Spouse
☐ Parent ☐ Adult Child ☐ Affidavit Next of Kin ☐ Other: _____

Note: If minor consented for their outpatient treatment for pregnancy, sexually transmitted disease or behavioral/mental health without parental consent, the minor must sign this authorization. When the patient is a minor being treated for substance abuse, the minor must sign this authorization, regardless of who consented for treatment.

Signature of Minor: _____ **Print Name:** _____ **Date:** _____

Authorization given to patient / Date of release: _____ via ☐Mail ☐Fax ☐Other _____ ☐ID Verified ☐DL/Other ID _____
Employee Name: _____ **Date:** _____

Atrium Health

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Information or Sticker

Name:
DOB:
Medical Record #: **Account #:**

Atrium Health

HEALTH REQUEST FOR TREATMENT AND AUTHORIZATION FORM

REQUEST FOR TREATMENT. The Charlotte-Mecklenburg Hospital Authority d/b/a Atrium Health ("Atrium Health"), maintains certain providers, personnel and facilities needed in providing me medical care, and I authorize Atrium Health to perform on me the care ordered by my providers. I understand that I have the right to be informed by my providers of the nature and purpose of any proposed treatment or procedure and any available alternative methods of treatment, together with an explanation of the likely risks and benefits associated with them. This form is not a substitute for such explanations, which are the responsibility of my providers to provide according to recognized standards of medical practice, and I acknowledge that Atrium Health and its personnel are not responsible for providing me this information for non-Atrium Health providers. I consent to receive services by interactive audio, video, or data communications to carry out consultations, evaluations, screenings, diagnosis, treatment, monitoring, or other communications benefiting a patient if appropriate for my condition, and I understand the risks, benefits and alternatives of doing so. I choose to receive the services even if an insurance plan may not cover or continue to cover specific services, including the specific services rendered during the medical treatment.

ASSIGNMENT OF INSURANCE BENEFITS. I/we hereby assign all my rights to Atrium Health under any policy of insurance, including but not limited to, major medical insurance, hospital or outpatient benefits, sick benefits, injury benefits due to me because of liability of a third party, such as auto insurance or Workers' Compensation insurance, and the proceeds of all claims resulting from the liability of the third party payable by any person, employer or insurance company to or for the patient up to the full amount of the medical bill, and hereby authorize direct payment to Atrium Health and/or my providers of all benefits to which I am entitled. This assignment includes payment of hospital, outpatient, surgical, and medical benefits as well as any professional group contracted by Atrium Health for professional services they may perform for me, including but not limited to radiology and imaging, anesthesia and pain services, pathology, radiation oncology, and emergency medicine services. In addition, I/we further warrant and represent that any insurance which I/we assign is valid insurance and in effect and that I/we have the right to make this assignment. I understand that I am financially responsible to Atrium Health, my providers, and those professional groups or entities included in this assignment for amounts due that are not covered by this assignment. For example, I know that sometimes insurance companies will not pay for services ordered by my providers and which I have authorized. I understand that these payment denials occur for a variety of reasons. My insurance policy may not include the particular service as a benefit. In other cases, a service will not be covered by my insurance company because it decides the service is not necessary, despite my provider's decision to order the service. In any event, even if a service is not covered by insurance, I agree to pay for all charges for all services rendered, including the specific services rendered as part of medical treatment. If Atrium Health deems necessary, I authorize Atrium Health to file member grievances on my behalf with my health plan for any denied claims. I appoint representatives of Atrium Health to act as my representative in pursuing such grievances. I further agree that in the event benefits paid under this assignment or any other amounts paid by me/us or on my/our behalf exceed the amounts due Atrium Health, my providers, or those professional groups or entities for services in connection with this medical treatment, any such excess amount may be applied to any other indebtedness that I or my spouse or any child for whom I am financially responsible may have to Atrium Health or any other facility or entity related to Atrium Health, my providers, or other professional groups or entities included in this assignment.

NOTICE OF INDEPENDENT CONTRACTORS. I understand that Atrium Health has contracted with certain independent professional groups for such groups to provide exclusively certain medical services at Atrium Health facilities, including but not limited to radiology and imaging, anesthesia and pain services, pathology, radiation oncology, and emergency medicine services. I understand that professional groups providing those services are independent contractors, are not employees or agents of Atrium Health, and are not subject to control or supervision by Atrium Health in their delivery of professional services.

USE OF MEDICAL INFORMATION. I understand that Atrium Health and my providers and independent professional groups providing medical services can use my information for treatment, payment, and health care operations, as further outlined in the Atrium Health Notice of Privacy Practices. As clarification, I understand that Atrium Health and my providers may give any medical information relating to my medical treatment to any insurance company, governmental or charitable and social service agencies and their agents, and professional review organizations with whom I may have insurance coverage or who may be assisting in payment of my medical treatment. I also understand that Atrium Health and my providers may release any medical information to any health care provider or medical facility to which I may be referred or transferred for further medical care or support services. I authorize Atrium Health and my provider to take and produce pictures, recordings, and/or videos of me for treatment and health care operation purposes. I can object to, or rescind my permission for, pictures, recordings, and videos being taken or produced for reasons other than treatment and health care operations at any time. In addition, I authorize Atrium Health and my providers to release any medical information necessary to prove Atrium Health's damages in any legal proceeding brought to enforce any unpaid balance on any of my accounts.

PHONE AND TEXT MESSAGE COMMUNICATIONS. I authorize Atrium Health and its representatives (including third-party agents) to contact me by phone using pre-recorded messages and/or automated dialing systems at any phone number associated with me or my personal representatives, including wireless numbers, in connection with any matter relating to my treatment, payment, or account, or to advise me of products or services that may be of interest to me. I can only decline to receive further calls or messages by following the reasonable instructions specifically provided by Atrium Health. I understand that I am not required to agree to receive phone calls and messages in order to receive treatment or other Atrium Health services. By providing my email address and cell phone number, I give permission for Atrium Health (including its agents and contractors) to send me information, reminders, and messages using those means of communication. I authorize Atrium Health to send me unencrypted messages using these means of communication, and I understand and accept the risks associated with doing so.

Atrium Health

AUTHORIZATION TO RELEASE MEDICARE AND MEDICAID INFORMATION. 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.

PAYMENT GUARANTY. I (patient and/or responsible party/ies) agree to pay all charges for services rendered by Atrium Health and my physicians and other providers for my medical treatment. This guaranty includes charges for services not covered by any insurance, regardless of the reason that insurance coverage is denied. I agree to pay the Hospital account I incur in accordance with the rates and terms of the Hospital at the time of my discharge. If I fail to pay all charges and Atrium Health or my providers use an attorney to collect unpaid charges, I agree to pay the reasonable cost of the attorney's services in addition to the unpaid charges. I consent and authorize Atrium Health and its agents and subcontractors to contact outside data sources of its choosing, including credit reporting agencies, for purposes related to my account, including evaluating and assessing my credit worthiness, my charity eligibility, and the viability of collecting any amounts due for the treatment I receive, whether at this time or on subsequent visits. I understand and agree that Atrium Health may assign my accounts as it deems necessary for purposes of collecting any amounts I owe, including to collection agencies and attorneys.

PERSONAL PROPERTY. I understand that Atrium Health is not responsible for money, valuables and other personal property in my possession and has no liability for their loss.

APPOINTMENT AND RELEASE FOR FINANCIAL PURPOSES. I appoint the Financial Counseling staff of Atrium Health as my (and the patient's) agent and personal representative for the purpose of initiating applications for Medical Assistance programs and/or conducting any and all activities associated with determining eligibility for such benefits, including, but not limited to, including Medical Assistance, Aid to Families with Dependent Children, and Special Assistance. The Financial Counselor may have access to and copy any records or information to which I would be entitled. I authorize and direct the County Department of Social Services to send copies of all notices, requests for information, and actions taken in my case including approvals and denials, and to provide such information to the Financial Counselor electronically or via telephone if requested. I authorize the Hospital, at its own expense, to obtain legal representation to assist in the evaluation, application or appeal processes. The doctrine of informed consent has been explained to me.

I have read the foregoing request and authorization in its entirety and agree to be bound by all terms and conditions herein. I acknowledge that this consent is voluntary and that it may be revoked by me in writing at any time except to the extent that action has already been taken in reliance on it. Unless otherwise revoked, this consent shall be valid for one (1) year from the date of authorization, or until final determination of any benefits application as described above, whichever is later; however, the consent will not expire for services, claims processing or collection activities for admissions or visits occurring while this consent was in effect. The undersigned hereby consents to such medical treatment as my provider(s) order and indicate the same by my (our) signature below. Witness my (our) hand(s) and seal(s) below.

Name of Patient: _____(Seal) Phone number: _____

_____(Seal)
Patient/Responsible Party Signature

Relation, if not Patient:
____Spouse
____Parent/s
____Other (Specify:_____)

_____
Date Time

_____
Witness Date Time

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o I have been provided access to Atrium Health's Notice of Privacy Practices

_____
Patient/Authorized Representative Signature

Relation, if not Patient:
____Spouse
____Parent/s
____Other (Specify:_____)

_____
Date Time

Reason Patient Unable/Unwilling to sign _____
_____

REQUEST FOR TREATMENT AND AUTHORIZATION FORM

PATIENT LABEL

901

NorthEast Plastic & Reconstructive Surgery

Patient Name: _____ Today's Date: ___/___/____

Primary Care Physician: _____ Date of Birth: ___/___/____

Referring Physician: _____

Reason for today's visit:

_____

_____

_____

For Physician Use Only
(HPI: Location, Duration, Timing, Severity, Quality, Modifying Factors, Signs & Symptoms, Context)

Current Medications:

_____

_____

_____

_____

Allergies:

_____

_____

_____

_____

Past Surgeries & Approximate Dates:

_____

_____

_____

_____

_____

_____

Previous Medical History:

_____

_____

_____

_____

_____

_____

200 Medical Park Drive, Suite 320 • Concord, North Carolina 28025 • 704-403-2760 • 704-403-2779 (fax)

NorthEast Plastic & Reconstructive Surgery

Medical History

Please mark Yes or No if you have had any of the following:

Stroke
○Yes ○No

Heart Disease
○Yes ○No

Stomach Ulcers
○Yes ○No

Hepatitis
○Yes ○No

Arthritis
○Yes ○No

Anemia
○Yes ○No

Other:
_____

HIV &/or AIDS
○Yes ○No

Glaucoma
○Yes ○No

Cancer
○Yes ○No

Asthma
○Yes ○No

Sleep Apnea
○Yes ○No

Blood Clots
○Yes ○No

Bleeding Tendency
○Yes ○No

Thyroid Disease
○Yes ○No

Rheumatic Fever
○Yes ○No

High Blood Pressure
○Yes ○No

Tuberculosis
○Yes ○No

Diabetes
○Yes ○No

Social History:

Do you currently smoke? ○Yes ○No If yes, amount per day: _____

Are you a former smoker? ○Yes ○No If yes, when did you quit? _____

Do you drink alcohol? ○Yes ○No If yes, amount per week: _____

Occupation: _____

Marital Status: ○M ○S ○D ○W

Recreational Activities:

_____

_____

NorthEast Plastic & Reconstructive Surgery

Family Medical History

Please mark Yes or No if any blood relative has had any of the following:

Breast Cancer
◯Yes ◯No

Heart Disease
◯Yes ◯No

High Blood Pressure
◯Yes ◯No

Hemophilia
◯Yes ◯No

Problems w/Anesthesia
◯Yes ◯No

Melanoma
◯Yes ◯No

Colon Cancer
◯Yes ◯No

Diabetes
◯Yes ◯No

Please note that a blood relative would be your:
Mother
Father
Paternal Grandparents
Maternal Grandparents
Aunt
Uncle
Brother
Sister

Review of Systems

Please mark Yes or No if you had any of the following symptoms in the past year:

Weight Changes
◯Yes ◯No

Chest Pain
◯Yes ◯No

Jaundice
◯Yes ◯No

Seizures
◯Yes ◯No

Joint Pain
◯Yes ◯No

Chronic Cough
◯Yes ◯No

Easy Bruising
◯Yes ◯No

Fever Blisters
◯Yes ◯No

Swollen Feet/Ankles
◯Yes ◯No

Nausea/Vomiting
◯Yes ◯No

Rapid Heart Beat
◯Yes ◯No

Depression
◯Yes ◯No

Easy Bleeding
◯Yes ◯No

Muscle Pain
◯Yes ◯No

Shortness of Breath
◯Yes ◯No

Trouble Urinating
◯Yes ◯No

Dry Eyes
◯Yes ◯No

Fever/Chills
◯Yes ◯No

I affirm that the above information is correct and I am not withholding any of my previous medical history, to the best of my ability.

Signature:

_____

Relation to Patient: _____

Date: _____