



Your Home for Medical Care

Welcome from Drs. Womble, Outlaw and Capps, Ms. Sarno and Ms. Ruiter.

Internal Medicine and Pediatrics Associates is your home for medical care. We want you to consider us your home base for all medical care. If you have a medical question after hours, we ask that you call us first before going to an Emergency Room or Urgent Care. In most cases a call to us will help guide you to the best solution to your after-hours needs.

There may be a time when you are under the care of specialists, hospital-based physicians, or mental health clinics. In all of these cases we still want you to see us as your home base for all medical care. Medicine can be confusing and unfortunately communication is not always at its best in high intensity settings like the hospital. If you have questions about your plan of care, we would like to help. We have Care Managers who may visit you in your home after a hospitalization to make sure that your ongoing plan of care is understood and that you have the best chance of staying out of the hospital.

We ask that you make an effort to connect us with whatever you do that relates to your medical care. If you see a specialist, have a diagnostic procedure or imaging study done, have an immunization somewhere else, or see a mental health clinic or hospital please take the time to provide information about our practice so that they may forward information to us, your medical home.

The providers at Internal Medicine and Pediatrics are trained to manage a wide variety of health concerns from guiding you through common illness to diagnosing more rare disease. Many people can find it difficult to access mental health care. We can help you in this by both providing basic care for anxiety and depression as well as referrals to appropriate mental health care professionals as needed.

We recognize that being without insurance or underinsured can often compromise health because of an inability to afford needed diagnostic tests, specialist care, and/or medications. If you are without insurance, we can provide you with information about how to access more affordable insurance options.

We look forward to working with you to achieve greater health.

The Doctors of Internal Medicine and Pediatrics Associates



Patient Name: _____ **Age:** _____ **DOB:** _____
Social Security #: _____

Parent's Name (IF PATIENT IS A MINOR)

Mother: _____
Father: _____

Race and Ethnicity: (Requested per Federal Guideline. Please Circle)

Ethnicity: Hispanic Non-Hispanic
Race: American Indian or Alaska Native Asian Native Hawaiian
Black or African American White Hispanic
Other

Home Address

Street: _____
City: _____ State: _____ Zip code: _____

Phone Numbers

Home: _____ Business: _____ Cell: _____

Text Consent for SMS Reminders: YES NO Home or Cell

By agreeing to SMS text messaging, I understand that I will primarily receive text reminders for health-related notifications. Data/Message rates may apply.

Patient's or Parent's Work Information

Occupation: _____
Employer: _____
Employer Address: _____

Patient's or Parent's Insurance Information

PRIMARY Insurance Company Name: _____
Insurance Company Address: _____
Primary Name on Policy: _____
Date of Birth: _____ Social Security #: _____
Subscriber ID #: _____ Group #: _____ Plan #: _____
If Primary Insurance is Medicare, please indicate either A or B here: _____

SECONDARY Insurance Company Name: _____
Primary Name on Policy: _____
Date of Birth: _____ Social Security #: _____
Subscriber ID #: _____ Group #: _____ Plan #: _____



Emergency Contact Information

Name: _____ Phone: _____

Relationship to Patient: _____

Who can we thank for referring you to our practice? _____

HIPAA Consent: I understand under HIPAA this office may use my Private Health Information (PHI) for treatment, payment, and health care without my signed consent. Signing below indicates that I have received notice of privacy practices (HIPAA Policy) to review.

Printed Name: _____

Signature: _____ **Date:** _____

Patient Portal Information and Consent

We are now offering an internet portal which allows secure electronic access to some of your medical record including lab reports and diagnostic imaging results.

The patient portal also allows secure and efficient email-based communication with the office. This is **not intended for urgent or emergent communications**. While we anticipate answering questions on the same business day, we cannot guarantee this. This is an alternative form of communication and not a replacement for traditional phone-based communication. All communications made via the portal will be included directly in your electronic medical record.

Your email information will not be shared with third parties. All email messages will be accessed through the portal and not your email account. Your email account will receive a notification message when there is a message to be viewed on the portal. Security, therefore, depends on you keeping your portal username and password secure. If you feel that someone has access to your password, we ask that you go immediately to the portal and change your password.

We reserve the right to deactivate portal access for any user that we deem is using the account inappropriately.

We can enable access to the patient portal today and provide you with a username and password. On initial login you will be prompted to reset your username and password. We will not have access to your password, and it is your responsibility to keep this secure.

Email Address: _____

I have read, understood, and agree to the above consent information.

Signature of Patient or Guardian: _____

The Patient Services Portal can be accessed through a link on our website at:

carymedpeds.com



James Womble, MD

David Outlaw, MD

Michael Capps, MD

Ersilia Sarno, FNP

Kristin Ruiter, FNP

Our Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. The following is a statement of our financial policy which we require you to read and sign prior to any medical services being rendered.

- 1. FULL PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS WE HAVE A CONTRACT WITH YOUR INSURANCE COMPANY.**
- 2. WE ACCEPT CASH, CHECKS, VISA, DISCOVER, AND MASTERCARD.**

Regarding Insurance:

We may or may not accept assignment of your insurance benefits. If assignment is taken, you still will be responsible for any deductibles or copayments at the time services are rendered. Your insurance policy is a contract between you and your company; we are not a party to that contract unless we also have a contract with your company. If your insurance company has not paid on your claim within 45 days, you will automatically be responsible for the balance.

Please be aware that some, and perhaps all, of the services provided may be deemed non-covered services or not medically necessary under Medicare and/or other medical insurance programs.

Regarding insurance plans where we are a participating provider, all copayments and deductibles are due at the time services are rendered. In the event your insurance coverage changes to a plan where we are not a participating provider, refer to the above paragraphs.

Usual and Customary Rates:

Our practice is committed to providing the best treatment to our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. The only exception to this policy is a plan where we are a contracted participating provider.

Missed Appointments:

Please help us serve you better by keeping scheduled appointments. Unless cancelled at least 24 hours in advance, you will be charged \$25 for missed appointments and no shows.

Minor Patients:

The adult parent or legal guardian accompanying the minor is responsible for payment of the minor patient's account regardless of who the insurance policy holder is. For unaccompanied minors, non-emergency treatment will be denied unless the minor is prepared to pay when services are rendered.

THANK YOU FOR UNDERSTANDING THE NECESSITY OF OUR FINANCIAL POLICY. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONCERNS REGARDING THE ABOVE FINANCIAL POLICY.

I HAVE READ, UNDERSTAND, AND AGREE TO THIS FINANCIAL POLICY:

Signature of Patient (If Patient is under 18, a Parent or Guardian must sign.)

Today's Date

Internal Medicine and Pediatrics Associates

Patient Questionnaire

Name: _____ DOB: _____ Date: _____
 Drug Allergies: _____

Please complete the following confidential questionnaire to help us better address your health care needs.

1. Do you have any specific concerns you would like to have addressed today? If so, please note them below:
 - a. _____
 - b. _____
 - c. _____
2. List all medications (including over the counter medications and herbal supplements) that you are taking. Include dosage and frequency. *(Please turn this form over and use the back if you need more space.)*

a. _____	d. _____
b. _____	e. _____
c. _____	f. _____
3. Please circle if you have ever been diagnosed with any of the following:

Allergic rhinitis	Diabetes	Glaucoma	High Blood Pressure	Syphilis
Anxiety	Diverticulosis	Gonorrhea	Irritable Bowel Syndrome	Tuberculosis
Arthritis	Elevated Cholesterol	Gout	Kidney Disease / Stones	Ulcers
Asthma	Emphysema	Heart Attack	Migraines	Other: _____
Chlamydia	Epilepsy / Seizures	Heart Disease	Osteoporosis	
Dementia	Gallstones	Hepatitis	Reflux	
Depression	Genital Warts	Herpes	Stroke or "Mini" Stroke	

Cancer (Type): _____

4. Are you currently under the care of any other physician? If so, please list:

a. _____	c. _____
b. _____	d. _____
5. List all operations (including outpatient) and their approximate dates:

a. _____	c. _____
b. _____	d. _____
6. What type of work do you do? _____

Where appropriate, please circle "yes" or "no" for each question.

7. Do you wear glasses or contact lenses? Yes No Date of Last Exam: _____
8. Do you or have you ever smoked? Yes No
If yes, packs per day: _____ Years: _____ Quit? _____ When? _____
9. Do you drink alcohol? Yes No
If yes, drinks per day: _____ Per Week: _____ Quit? _____ When? _____
10. Do you use any illegal drugs or have you in the past? Yes No
11. Do you get regular aerobic exercise? Yes No Please Describe: _____
12. In what year did you get your last tetanus shot? _____
13. Have you ever had the pneumonia vaccine? Yes No
14. Have you ever had a colonoscopy? Yes No If yes, what year was your last one? _____
15. Please circle if a blood relative (grandparent, parent, sibling, or child) has ever had any of the following diseases:

Diabetes	Elevated Cholesterol	Heart Disease	High Blood Pressure
Other: _____ Cancer (type): _____			

16. For Women Only

- a. Have you ever been pregnant? Yes No
If yes, how many times? _____ Number of children? _____ Date of last menstrual period? _____
- b. Are you sexually active? Yes No
If yes, how many sexual partners do you have? _____ Is (Are) your sexual partner(s) male or female? _____
- c. Do you use birth control? Yes No
If yes, what kind? _____ Date of last Pap smear? _____
- d. Have you ever had an abnormal Pap smear? Yes No
If yes, when? _____ Date of last mammogram? _____
- e. Do you do breast self-examinations? Yes No
- f. Have you ever had a Bone Density Scan? Yes No If yes, year of last scan: _____

17. For Men Only

- a. Are you sexually active? Yes No
If yes, how many sexual partners do you have? _____ Is (Are) your sexual partner(s) male or female? _____
- b. Do you do testicular self-examinations? Yes No
- c. Have you ever had your PSA checked? Yes No If yes, year of last check: _____