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, weask 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

Internal Medicine
& Pediatrics Associates
Doctors for Adults and Children

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 #:_____

Internal Medicine
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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

Internal Medicine
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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**

Patient Name:_____DOB:_____ Today's Date: _____

Internal Medicine and Pediatrics Associates, PA

PEDIATRIC NEW PATIENT QUESTIONNAIRE

Reason/ Concerns for Today's Visit:

1._____
2._____
3. _____

CURRENT MEDICATIONS (including vitamins, herbs, and over-the -counter)

1._____3._____
2._____4. _____

Do you have any **Allergies to Medications**? __Yes___No **Food Allergies**? __Yes___No
If so please list: _____
Any special diet? _____

BIRTH HISTORY (Newborn only)

Where was your child born? _____
How many weeks gestation at birth? _____
Birth weight:_____Discharge weight:_____Breastfeeding?_____Yes____No
Did your child pass their newborn hearing screening test?____Yes____No
Any jaundice requiring treatment?____Yes_____No
Any maternal illnesses, smoking, alcohol use, or medications during pregnancy?
Please List: _____

MEDICAL HISTORY

Prior medical illness: _____
Hospitalizations:_____
Surgeries:_____
Dentist:_____
Other Physicians currently caring for your child:
_____

FAMILY HISTORY

Please list medical conditions for the family members below?

Mother:_____

Father:_____

Siblings:_____

Grandmother:_____

Grandfather:_____

SOCIAL HISTORY

Who is your child's legal guardian? _____
Who cares for you child during the day? _____
City water____Yes____No Well water Yes No
Is your child exposed to tobacco smoke inside the home/ car?____Yes____No
Any guns in the home?____Yes____No
Any pets in your home? __Yes____No If so, please list type_____
Has your child traveled abroad?____Yes____No Where? _____

OVER >>>

Patient Name: _____ DOB: _____ Today's Date:_____

List all the people who live in your household and their relationship:

Name	Relationship to Patient
1.	
2.	
3.	
4.	
5.	
6.	

AUTHORIZATION FOR MEDICAL CARE

Names listed below may authorize medical care or accompany your child to their medical visits. This allows them to receive **medical advice over the phone**, **bring the child to appointments**,**consent to medical treatments,** and care for my child in my absence.

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship: _____

Name of person completing this form_____Signature _____

Relationship to child_____ Date_____