Appalachian Regional Internal Medicine Specialists

a practice of Appalachian Regional Medical Associates

Main level of the "Boone Point Building"
148 Hwy 105 Extension | Suite 104 | Boone, NC 28607
(828) 386-2746 | fax: (828) 386-2750
email: *appinternalmed@apprhs.org* | web: *apprhs.org/arims*

Thank you for choosing Appalachian Regional Internal Medicine Specialists as your healthcare provider. We look forward to seeing you at your appointment.

This new patient information packet includes directions to our office and contact information for you to keep for your records. Enclosed is the paperwork that you will need for your upcoming appointment. Please complete the paperwork and bring it with you at your appointment time. Our Billing & Insurance Information, Notice of Privacy Practices and Patient Bill of Rights & Responsibilities are available at the front desk or online at *apprhs.org*.

Appalachian Regional Internal Medicine Specialists, a practice of Appalachian Regional Medical Associates, treat the whole person, not just the illness. Our **internal medicine** services focus on prevention and wellness strategies, new treatment options and emerging health strategies. Our **rheumatology** services focus on diagnosis and treatment of rheumatic diseases including arthritis, autoimmune diseases and osteoporosis. Our **Women's Health** services include Well Woman Visits which is an annual preventive care exam for adult women to receive comprehensive evaluation services, counseling and screenings. We offer Annual Wellness Visits to our Medicare patients.

Same-day acute care (sick or injured) appointments are available for established patients.

To schedule an appointment, please call (828) 386-2746 or send an email to appinternalmed@apprhs.org. This email is for scheduling appointments only. Please do not send personal health information through email. If your email is received before 4:00 p.m., you will receive a call or email the same day.

Our office is available to you by phone from 7:00 a.m. - 5:00 p.m. Monday - Friday. If you have any questions, please call our office manager at (828) 386-2746.

To learn about the providers at this location, visit *apprhs.org/arims*

_____

has an appointment with

_____

☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri.

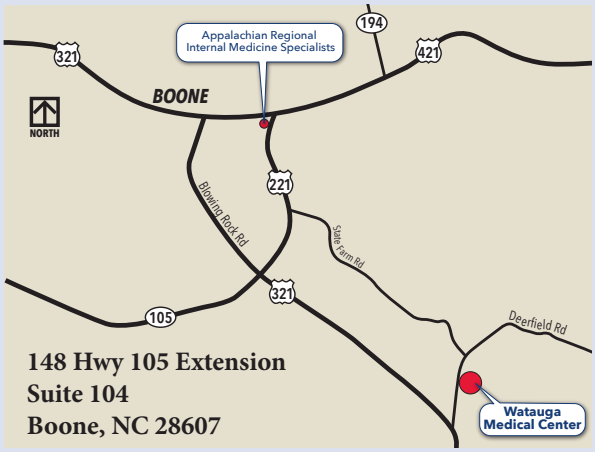
_____date _____a.m./p.m.

To reschedule your appointment, please call (828) 386-2746 or email *appinternalmed@apprhs.org.*

NEW PATIENT CHECKLIST:

For your first appointment please arrive 15 minutes early and bring the following:

☐ Insurance Card
☐ Pharmacy Information
☐ Medical Records
☐ Payment
☐ Current Medications/Prescription Bottles
☐ Questions for doctor
☐ Completed forms
☐ Photo ID



APPALACHIAN REGIONAL MEDICAL ASSOCIATES
Patient Registration

Patient Name_____
Date of Birth_____
Phone Number_____
Please Fill in or Affix a Patient Label

Patient Name: First M/I Last

Gender: ☐Male ☐ Female **Date of Birth:** ____/____/_____ **Social Security #:** _____-_____-_____

Marital Status: ☐Married ☐Single ☐Divorced ☐ Separated ☐Widowed ☐ Life Partner

Mailing Address: Street-

City- State- Zip Code-

Primary Phone #: _____ ☐ **Cell** ☐ **Home**

Secondary Phone #: _____ ☐ **Cell** ☐ **Home**

Work Phone #: _____ **Employer/Occupation:** _____

E-mail: _____

Emergency Contact: _____ **Phone #:** _____

I consent to Appalachian Regional Medical Associates ("ARMA") or its representatives:
☐ calling my phone and leaving a message ☐ e-mailing me
about balances due, financial assistance, appointments, pre-registration, lab results, and other healthcare information. Methods of contact may include pre-recorded voice messages and the use of automatic dialing services.

What is your ethnicity? ☐Hispanic or Latino ☐ Not Hispanic or Latino

Select one or more races to indicate what you consider yourself to be: ☐Asian ☐ White
☐ American Indian or Alaskan Native ☐ Black or African American ☐Native Hawaiian or other Pacific Islander
☐ Other: _____

Preferred language? ☐ English ☐ Spanish ☐Other: _____

How did you hear about us?
☐ Billboards ☐Doctor ☐Friends/Family ☐Magazine ☐Newspaper ☐Social Media ☐Radio ☐TV
☐ARHS Website ☐Other _____

If patient is a minor please print Guardian Name:
First: _____ M/I: _____ Last: _____

If patient has a guarantor (someone else responsible for the bill) please provider information below:

Patient's relationship to Guarantor: _____

Guarantor's Name: First: _____M/I:_____Last:_____

Mailing Address: Street-_____

City-_____State-_____ Zip-_____

Date of Birth: ____/____/_____ Social Security #: _____-_____-_____ Phone #: _____

Employer: _____ Employer Phone #: _____

Signature of Patient/ Legal Representative ▶	Date: Time:
Name of Patient/ Legal Representative *(Please Print)* ▶	Relationship of Legal Representative ▶

Effective Date: Not Set
Revised Date: 04/20/2018
Form Number: 11332

APPALACHIAN REGIONAL MEDICAL ASSOCIATES

Appalachian Regional Internal Medicine Specialists

Patient Name_____
Date of Birth_____
Phone Number_____
Please Fill in or Affix a Patient Label

Medical History

Please list any hospital stays, surgical operations, or serious illnesses, starting with the most recent.

Hospital stays, surgical operations, serious illnesses	Date	Hospital
1.		
2.		
3.		
4.		
5.		

Have you ever received any blood transfusions? ☐**Yes** ☐**No** **When?** _____

Drug Allergies: (Please include type of reaction) ☐**Yes** ☐**No**

Drug Name_____ Reaction_____

Drug Name_____ Reaction_____

☐Latex Allergy ☐Contrast/ IV Dye/ Shellfish Allergy

Medication List: ☐**None**

(list names, dosages and frequency of all medications, aspirin, OTC meds and vitamins)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Social History:

Tobacco Use: ☐**Yes** ☐**No** ☐**Never used**

☐**Cigarettes** ☐**Other tobacco** _____ **Year(s) Smoked** _____ **Pack(s)/day**

☐**Former tobacco use** _____ **Year(s) Smoked** _____ **Pack(s)/day**

Alcohol Use? ☐**Yes** ☐**No** ☐**Never used**

If yes, how much?

Illicit Drug Use? ☐**Yes** ☐**No** ☐**Never used**

If yes, please specify:

Caffeine Use? ☐**Yes** ☐**No** ☐**Never used (coffee, soda, tea)**

If yes, how much?

Effective Date: 12/13/2012
Revised Date: 04/13/2017
Form Number: 10680

APPALACHIAN REGIONAL MEDICAL ASSOCIATES

Appalachian Regional Internal Medicine Specialists

Patient Name_____
Date of Birth_____
Phone Number_____
Please Fill in or Affix a Patient Label

Check if you have or family member has ever had, any of the following conditions:

	You	Family		You	Family
Unexpected weight change of more than 10 lbs In the past year			Asthma		
			Birth defects		
Serious problems with eyes or ears			Bleeding problems		
Persistent swollen glands/unusual lumps			Cancer		
Breast lumps or unusual discharge			Lung diseases		
Irregular or fast heartbeat			Depression		
Chest pains or tightness			Sickle cell		
Frequent swelling of ankles or legs			Diabetes		
Unusual skin problems or persistent sores			Heart attack		
Redness, severe pain or swelling of joints			Heart disease		
Frequent or severe back pain			High blood pressure		
Change in appetite			High cholesterol		
Difficulty swallowing			Mental retardation		
Frequent or severe abdominal pain			Nervous breakdown		
Frequent nausea or vomiting			Seizures		
Frequent or severe constipation/diarrhea			Stroke		
Blood in a bowel movement			Thyroid problems		
Black or tarry stools					
Pain or burning with urination					
Genital problems					
Problems with pregnancy					

What questions do you wish to ask the doctor?

1 _____

2 _____

3 _____

Do you have a living will or Health Care Power of Attorney? ☐ Yes ☐ No
(If Yes please bring a copy with you to your appointment.)

I certify that the above information is correct to the best of my knowledge:	
Signature of Patient/Legal Representative ▸	Date: Time:
Printed Name of Legal Representative ▸	Relationship of Legal Representative ▸

Signature of Reviewer (*OFFICE USE ONLY*) ▸	Date: Time:

Effective Date: 12/13/2012
Revised Date: 04/13/2017
Form Number: 10680

APPALACHIAN REGIONAL MEDICAL ASSOCIATES

Appalachian Regional Internal Medicine Specialists

Affix a Patient Label

Authorization to Release and Consent

Consent for Diagnostic and Treatment

I hereby request and consent to diagnostic and medical treatment given to me at Appalachian Regional Internal Medicine Specialists, a physician practice of Appalachian Regional Medical Associates, Inc. (hereinafter "ARMA"), which may include routine diagnostic procedures and medical treatment which my physician or another practitioner involved in my care considers necessary. I am aware that the practice of medicine (including surgery) is not an exact science, and no one has made any guarantees about the results of my treatments, examinations, or procedures.

Certification, Assignment of Insurance Benefits, and Guaranty of Payment

I certify that the information I have given in applying for payment under Medicare, Medicaid, or any other government or private insurance program is correct. I hereby authorize payment of surgical and medical benefits directly to my physician and/or directly to ARMA, as applicable. I authorize ARMA to bill my insurer directly, and I assign to ARMA the right to receive all health and liability insurance benefits otherwise payable to me. I understand that I am financially responsible for, agree to pay, and guarantee payment in full of all charges for services provided to me by ARMA and my physician, even if such services are not covered by insurance. I also understand that my insurer may not pay the full amount of my charges, and I may be responsible (as the patient, spouse, or the parent of a minor child) for the amount not paid. I understand that my bill will be sent to my address on file unless I request my bill to be sent to a different address. I acknowledge that in addition to receiving a bill from ARMA, if I receive pathology, laboratory, or imaging services, I will receive a separate bill from the respective provider of those services. I authorize ARMA to act as attorney-in-fact (act with authority from me) for the limited purposes of: (1) billing directly and collecting benefits from any responsible third party through whatever means necessary; and (2) endorsing benefit checks made payable to me and/or ARMA or my physician. If collection efforts are needed to obtain payment from me for the services and supplies provided, I agree to pay the costs of such collection efforts, including reasonable attorneys' fees. I authorize payment of any refund of any overpaid insurance benefits to be made to the appropriate insurer in accordance with my insurance policy conditions or any applicable benefit provisions. If any refund is due to me, I authorize the application of such refund to any amount that I am personally legally obligated to pay for services provided by ARMA. I understand that any remaining credit due after payment of these outstanding amounts will be refunded to me.

Use and Release of Health Information

I acknowledge that licensed physicians and other health care professionals involved in my care at ARMA may use and release my health information obtained during this visit for purposes of treatment, payment, and health care operations as stated in the ARMA Notice of Privacy Practices.

My health information, or information about payment for my medical treatment, may be shared with the following friends, family members, or authorized representatives:

Name: _____ Relationship: _____ Phone: _____

Limitations to disclosure (if any):_____

Name: _____ Relationship: _____ Phone: _____

Limitations to disclosure (if any):_____

Name: _____ Relationship: _____ Phone: _____

Limitations to disclosure (if any):_____

Note: A separate form must be completed by the patient to release written health information (e.g., medical records) to family members, friends, or other authorized representatives.

Effective Date: 03/01/2012

Revised Date: 07/20/2018

Form Number: 10623

APPALACHIAN REGIONAL MEDICAL ASSOCIATES

Appalachian Regional Internal Medicine Specialists

Affix a Patient Label

Acknowledgment of Receipt of Notice of Privacy Practices and Financial Information

If I am a first-time patient, I certify that I have received a copy of the ARMA Notice of Privacy Practices. If I am a returning patient, I understand that a copy is available to me upon request. I have had the opportunity to review the ARMA financial information brochure.

Appointment No-Shows and Late Cancellations- $25.00 Fee

Any patient who fails to arrive for a scheduled appointment, without prior notification 24 hours in advance, is considered a "no-show." Patients must contact the office with at least 24 hours' notice to cancel or reschedule their appointment to avoid being charged a $25.00 fee. New patients that "no-show" two consecutive times to an appointment will be excluded from making future appointments with that provider. Established patients who "no-show" three consecutive times, or three times within a 12-month period, may be discharged from the practice.

I understand that this consent will automatically expire in one year. I also understand that I may revoke or withdraw my consent at any time by notifying ARMA in writing, but my withdrawal will not be effective for actions already taken based upon my consent. I understand and agree to the above releases, authorizations, consents, and assignments of benefits.

Signature: _____ **Date:** _____ **Time:** _____
(Patient or legal guardian/authorized representative, if patient unable to sign)

Printed Name: _____ **Relationship, if not patient:** _____

Guardian or Representative, if any: *(Please print name)* _____

Signature: _____ **Date:** _____ **Time:** _____
(Insured/Guarantor, if different from Guardian/Representative)

Insured/Guarantor, if any: *(Please print name)* _____

Effective Date: 03/01/2012
Revised Date: 07/20/2018
Form Number: 10623