Davant Clinic

The Harriet and Charles Davant, Jr. Medical Clinic
a practice of Appalachian Regional Medical Associates

623 Chestnut Ridge Pky | Blowing Rock, NC 28605
828-386-3350 | fax 828-386-3352
apprhs.org/davantclinic

Thank you for choosing The Harriet & Charles Davant, Jr. Medical Clinic at Chestnut Ridge 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*.

The Davant Clinic is committed to providing the finest quality, evidence-based medical care available. The goal of the practice is to help patients achieve and preserve the best quality of health/life for as many years as possible. Committed to lifelong learning, our providers, welcome questions on new and emerging treatments and strategies for preventive health.

As a practice of Appalachian Regional Medical Associates, the Davant Clinic provides comprehensive care for patients 6-years and older.

Conditions and services offered: cold & flu, complete physical exams, falls, family medicine, fever, injuries, Medicare Annual Wellness Visit, preventative care, primary care, gynecology and women's health services.

Our office is available to you by phone on Monday through Friday from 8:00 am - 5:00 pm. If you have any questions, please call our office manager at 828-386-3350. After hours, please call Watauga Medical Center at (828) 262-4100 and ask for the provider on call to be paged.

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

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
- ☐ Questions for doctor
- ☐ Completed forms
- ☐ Information from previous doctor

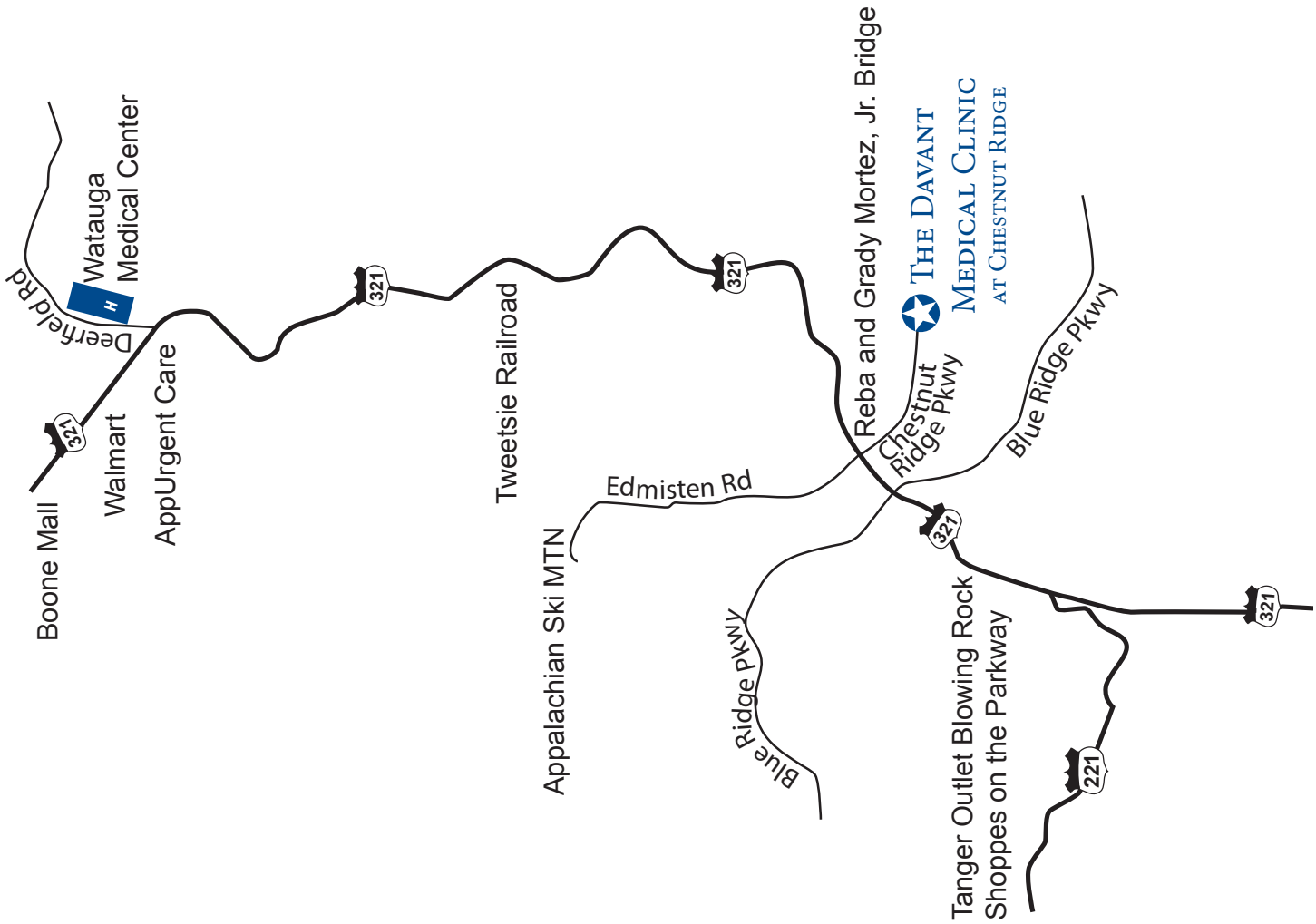
_____
has an appointment with

_____

☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri.

_____date _____a.m./p.m.

To reschedule your appointment, please call (828) 386-3350.



THE DAVANT MEDICAL CLINIC
AT CHESTNUT RIDGE
623 Chestnut Ridge Parkway | Blowing Rock, NC 28605

STAMP

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

Davant Medical Clinic

Patient Name_____

Date of Birth_____

Phone Number_____

Please Fill in or 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 Davant Medical Clinic, 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: 06/22/2016

Revised Date: 07/23/2018

Form Number: 11118

APPALACHIAN REGIONAL MEDICAL ASSOCIATES

Davant Medical Clinic

Patient Name_____

Date of Birth_____

Phone Number_____

Please Fill in or 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)* _____

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