SmithFamilyWellnessCenter.com

Patient Contact Information Today's Date: _______________

First Name: __________________________ Last Name: ____________________ Middle: ____________
Name of Parent/Guardian: ____
Date of birth: _____________ Age: _______ Gender: M F Social Security # _____________________
Street Address: ____
City: _______________________________ State: ___________ Zip: _______________________________
Phone Number: (cell) ____________________________ (home) __________________________________
Email Address: ____
Emergency Contact Name: ________________________________ Phone: ____________________________
Country of Origin: ___________________________________ Primary Language: ________________________
Religious Preference: _______________________________

Race/Ethnicity: Asian Caucasian Native American African American Hispanic
(Circle all that apply) Native Hawaiian/Pacific Islander Other: ________________
Length of Time in United States: _______________________ English Level (1-5, 5=fluent): ________________
Annual Household Income: (Circle one)

($0 to 9,999) ($10,000 to 14,999) ($15,000 to 24,999) ($25,000 to 34,999) ($35,000 to 49,999) ($50,000+)

Immediate Family Members:

First Name, Middle Initial, Last Name	Date of Birth (XX/XX/XXXX)	Relationship	Does family member have insurance? If so, please list type here. (Medicare, Private, Family Planning, etc.)

Before coming to Smith Family Wellness, where did you go for medical care? (Circle one)
Emergency room Community Medical Clinic Presbyterian/Novant Free Clinic
Private Practice: __________________ Did not have a medical home Other: ___________
Do you have a primary care doctor? __________ Physician Name: ___________________________________
How many times have you been to the ER in the past 12 months? _______ Reason: _____________________

Do you have Medical Insurance? Medicaid Medicare Private Other None

Insurer Name & Address: ____

Subscriber #: __________________ Customer Service #: __________________ Plan/Group#: ________________

Subscriber's name: __________________________ Subscriber's Date of Birth: _____________________________

Where did you hear about Smith Family Wellness Center? (Circle one)

Private Healthcare Provider Hospital Health Department Other Clinic School

Social Security Agency Media (newspaper, TV, radio) Church/Faith Community Family/Friend

Social History

Smoker: Yes No If yes, how much and how long? ____

Alcohol Intake: None Occasional Weekly Daily

Drugs: Yes No If yes, name and frequency: ____

Medical History

Allergies (Drugs, Food, Environmental) ____

____

____

Current Medications:

Name	Dosage

Past Medical History (Medical Diagnoses/On-Going Medical Conditions):

Condition	Family History (Relationship)	Condition	Family History (Relationship)
Cancer Yes No		Back Pain Yes No	
High Blood Pressure Yes No		Arthritis Yes No	
Heart Disease Yes No		Kidney/Urine pain Yes No	
Diabetes Yes No		Menstrual Issues Yes No	

Thyroid Yes No		Vision Problems Yes No	
Liver Disease Yes No		**Mental Disorders:**	
Asthma Yes No		Anxiety Yes No	
Constipation Yes No		Depression Yes No	
Diarrhea Yes No		Bipolar Disorder Yes No	
Migraines Yes No		ADHD Yes No	
Stroke Yes No		PTSD Yes No	

If yes to any of the above or if you have additional conditions, please explain:

____

____

Menstrual History (Women Only):

Age of onset: _______________ Regular: Yes No Duration: ___________ days

Date of Last Period: ________________________

Number of Pregnancies: ___________________ Number of Miscarriages/Abortions: ________________

Complications (Premature, Caesarian, etc.): ____

If yes to any of the above, please explain:

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____

Consent for Healthcare and Release of Medical Information

I voluntarily consent to healthcare treatment from the physicians and staff at this clinic. I am aware that the practice of medicine is not an exact science. No guarantees have been made to me regarding the result of treatments or examinations by caregivers. I consent to the storage, use and disclosure of protected health information about me for treatment and healthcare operations. I have read this form and/or have had this form explained to me in full and have had the opportunity to ask questions and my questions have been answered.

I have received and/or a copy of the Privacy Practices of this clinic has been available to me. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the notice from this clinic.

Client Name (Print) ____

____ ______________________________

Signature of Patient or Authorized Person Date

Appointments

Appointments can be made by contacting 704-910-5810, faxing a referral to 980-207-0214, or completing the on-line form at http://www.smithfamilywellnesscenter.com/appointments.html. **Cancellations should occur 24 hours in advance** of the appointment by calling 704-910-5810. If you do not show for your appointment and fail to notify the clinic at least 24 hours before the session, you will be charged the $10 cancellation fee, unless prohibited by your insurance. After 3 missed appointments, patients will be ineligible to schedule an appointment for a minimum of 6 months.

Counseling Fees

The minimum fee for individual and family therapy is $10/session. The minimum fee for group therapy is $5/session plus childcare fee when applicable. The value of a one-hour counseling session is $100. It is the goal of the Smith Family Wellness Center to provide access to medical and mental healthcare without placing additional financial strain on the family. Fees and payment schedule will be assessed on a case-by-case basis accounting for household income, household size, and expenses. The total fee for churches sponsoring a client will be $50/session. It is required that the client pay a percentage decided by the deacons or other church leadership. Clients will be responsible for the full session fee for missed appointments or appointments cancelled less than 24 hours in advance (non-Medicaid clients only). Appointments can be cancelled by calling 704-910-5810 or by emailing your counselor.

Confidentiality and files: Notice of Privacy Policies and Practices

To comply with Federal HIPAA regulations concerning safety of Health Care Information, Smith Family Wellness Center provides every individual with the opportunity to read the Notice of Privacy Practices (see below). This form acknowledges that you had the opportunity to do so and ask questions.

Acknowledgement of Receipt of Privacy Notice

Client Name: ______________________________

Date of Intake: _____________________________

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Smith Family Wellness Center's Notice of Privacy Practices. I understand that if I have any questions regarding this Notice of Privacy Practices or of my privacy rights, I can contact my therapist.

____ _______________

Signature of Client Date

____ _______________

Signature of Parent, Guardian or Personal Representative Date

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Your health record contains personal information about you and your health. State and federal law protects the confidentiality of this information. "Protected health information" (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. If you suspect a violation you may file a report to the appropriate authorities in accordance with Federal regulations.

Your rights regarding your PHI:

You have the following rights regarding PHI I maintain about you:

Right of Access to Inspect and Copy. You have the right, which may be restricted only in certain limited circumstances, to inspect and copy PHI that may be used to make decisions about your care. I may charge a reasonable, cost-based fee for copies.

Right to Amend. If you feel that the PHI I have about you is incorrect or incomplete, you may ask me to amend the information although I am not required to agree to the amendment.

Right to an Accounting of Disclosures. You have the right to request a copy of the required accounting of disclosures that I make of your PHI.

Right to Request Restrictions. You have the right to request a restriction or limitation on the use or of your PHI for treatment, payment, or healthcare operation. I am not required to agree to your request.

Right to Request Confidential Communication. You have the right to request that I communicate with you about medical matters in a certain way or at a certain location. I will accommodate reasonable requests and will not ask why you are making the request.

Right of Complaint. You have the right to file a complaint in writing with me or with the Secretary of Health and Human Services if you believe I have violated your privacy rights. I will not retaliate against you for filing a complaint.

Treatment. Your PHI may be used and disclosed by me for the purpose of providing, coordinating, or managing your health care treatment and any related services. This may include coordination or management of your health care with a third party, consultation with other health care providers or referral to another provider for health care services.

Payment. I will not use your PHI to obtain payment for your health care services without your written authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities.

Healthcare Operations. I may use or disclose, as needed, your PHI in order to support the business activities of my professional practice. Such disclosures could be to others for health care education, or to provide planning, quality assurance, peer review, administrative, legal or financial services to assist in the delivery of health care, provided I have a written contract requiring the recipient(s) to safeguard the privacy of your PHI. I may also contact you to remind you of your appointments, inform you of treatment alternatives and/or health-related products or services that may be of interest to you.

Use and Disclosures that <u>do not</u> require your authorization or opportunity to object:

Required by Law: I may use or disclose your PHI to the extent that the use or disclosure is required by law, made in compliance with the law, and limited to the relevant requirements of the law. Examples are public health reports and law enforcement reports. I also must make disclosures to the Secretary of the Department

of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of the Privacy Rule.

Health Oversight: I may disclose PHI to a health oversight agency for activities authorized by law, such as professional licensure. Oversight agencies also include government agencies and organization that provide financial assistance to me (such as third-party payers).

Abuse or Neglect. I may disclose your PHI to a state or local agency that is authorized by law to receive reports of abuse or neglect. However, the information I disclose is limited to only that information which is necessary to make the initial mandated report. I may disclose PHI regarding deceased patients for the purpose of determining the cause of death, in connection with laws requiring the collection of death or other vital statistics, or permitting inquiry into the cause of death.

Research. I may disclose PHI to researchers if (a) an Institutional Review Board reviews and approves the research and an authorization or a waiver to the authorization requirement; (b) the researchers establish protocols to ensure the privacy of your PHI; and (c) the researchers agree to maintain the security of your PHI in accordance with applicable laws and regulations.

Threat to Health or Safety. I may disclose PHI when necessary to prevent a serious threat to your health and safety or the health and safety to the public or another person.

Criminal Activity on my Business Premises/Against Me and My Staff. I may disclose your PHI to law enforcement officials if you have committed a crime on my premises or against me or my staff.

Compulsory Process. I will disclose your PHI if a court of competent jurisdiction issues an appropriate order. I will disclose your PHI if you and I have each been notified in writing at least fourteen days in advance of a subpoena or other legal demand, and no protective order has been obtained, and I have satisfactory assurances that you have received notice of an opportunity to have limited or quashed the discovery demand.

***For additional information see GS 122C 52 through 56**

Uses and Disclosures of PHI with your Written Authorization

Other uses and disclosures of your PHI will be made only with your written authorization. You may revoke this authorization in writing at any time; unless I have taken an action in reliance on the authorization of the use or disclosure you permitted, such as providing you with health care services for which I must submit subsequent claim(s) for payment.

This Notice

This Notice of Privacy Practices describes how I may use and disclose your protected health information in accordance with all applicable law. It also describes your rights regarding how you may gain access to and control your PHI. I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of my Notice of Privacy Practices at any time. I will make available a revised Notice of Privacy Practices by providing one to you at your next appointment or mailing you a copy of your request.

Contact Information

If you have any questions about this Notice of Privacy Practices, please contact the Smith Family Wellness Center Privacy Officer, Diana Moser-Burg, at 704-910-5810.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint in writing to Diana Moser-Burg, the SFWC Privacy Officer, as specified on this notice. There will be no retaliation against you for filing a complaint. You may file a complaint with the U.S. Secretary of Health and Human Services.

Consent for Billing Form

Client Name: ______________________________ Client #: ________________

Release of Information to Insurance

I hereby authorize Smith Family Wellness Center to send any and all information necessary to my health insurance carrier in order to bill for services rendered. Additionally, I authorize my insurance carrier to send payment directly to Smith Family Wellness Center. I understand that I may refuse to have my insurance company billed, but if I do refuse, I may be required to pay the full amount charged with no fee reduction. The information released could include alcohol and drug treatment.

Client's Responsibility

I understand that I am fully responsible for any unpaid balance remaining after any applicable insurance payment is made. If I am not eligible for insurance or if my insurance company refuses to pay, I understand that I am responsible for the entire balance for services rendered and this may be based on a sliding fee scale, if applicable. I further understand that Smith Family Wellness Center will bill my insurance as an accommodation.

I understand that charges may be based on a sliding fee scale, based upon net income, family size, and household expenses. I understand that my full cooperation is needed in order to determine the applicable sliding fee scale payment. I understand it is my responsibility to provide documentation of income and for deductions from income for medical and child care expenditures. I understand that providing false information to avoid financial liability can result in 100% responsibility for the charges.

I further understand that it is my responsibility to notify Smith Family Wellness Center immediately should my financial situation change. Should a change occur, I understand that any payment arrangements previously agreed upon could change.

I understand that I will be able to obtain an estimate of the costs of services that have been recommended. I understand that failure of payment to Smith Family Wellness Center may result in the enforcement of collection procedures and legal action.

I understand that my lack of cooperation in submitting any necessary information regarding insurance eligibility constitutes a refusal to cooperate and may result in refusal of services. I also understand that, unless otherwise specified in these provisions, I am responsible for all co-payments and deductibles required by my insurance carrier.

I understand that the address and phone numbers on the intake form will be used for any communication regarding my billing. I understand that it is my responsibility to notify Smith Family Wellness Center if my address changes.

I hereby certify that I have read and understood the above information and certify that all information given to Smith Family Wellness Center is true and correct.

Authorization for release of medical and treatment information: I authorize Smith Family Wellness Center to furnish any medical information relating to my treatment to my insurance company, governmental agencies and their agents, and professional review organizations with whom I may have insurance coverage or who may be assisting with treatment. This authorization will expire one (1) year from the date shown below, and I understand that I or my legal representative may revoke this authorization at any time, except to the extent that action has already been taken, or in the event of my death, the release of billing and treatment information is necessary to verify any charges incurred by me.

Authorization to release information to Medicare, Medicaid and other State Funded Programs: 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. I understand that health care services paid for under the Medicare, Medicaid, and other State Funding Programs are subject to review by professional organizations which may recommend denial of payment if my condition does not warrant continued treatment. I, authorize those agencies responsible for determining eligibility to provide to Smith Family Wellness Center any information relating to the determination of my eligibility. I request payment of benefits under these programs be made to Smith Family Wellness Center, on my behalf.

_______________________________________ ____________________

Client/Parent/Guardian Signature Date

For inquiries regarding billing or notification of change in address or financial status, please write or call:
Smith Family Wellness Center at Project 658
3622 Central Ave, Charlotte, NC 28205
704-910-5810

Access to Services

Regular clinic hours are from 9am-5pm, Monday-Friday, with additional Saturday clinics on the 2nd Saturday of each month from 9am-1pm. Emergency support is available during regular office hours by calling 704-910-5810, and additional support is available after hours by calling the office number and leaving a voicemail on your clinician's mailbox indicating an immediate response is needed. In addition, if it is a medical emergency that requires immediate attention, dial 911 first, and then call your clinician's mailbox for additional support as needed.