Health Partners
A division of Senior Care Systems, P.A.

1013 Porters Neck Road, Suite 100
Wilmington, NC 28411
Phone: (910) 686-1099
Fax: (910) 686-4715

PATIENT DEMOGRAPHICS & FINANCIAL INFORMATION

Patient's Name: _____
(Last) (First) (MI) (Maiden)

Address: _____
(Street/PO Box #) (Apt #)

_____
(City) (State) (Zip Code)

Phone - Home:_____Cell:_____ Preferred Contact: HOME CELL

Email Address:_____(Needed for Patient Portal Access)

Date of Birth: _____ Age: _____ MALE FEMALE

Marital Status: M SINGLE SEP W D Employer: _____

Primary Insurance: _____
(Company) (Group #) (Identification #)

Insurance Address: _____

Secondary Insurance: _____
(Company) (Group #) (Identification #)

Insurance Address: _____

Patient's Relationship to the Insured: SELF SPOUSE CHILD OTHER (If not SELF, please fill out below)

Insured's Name and Date of Birth: _____ _____/_____/_____

Insured's Place of Employment: _____ Phone: _____

Insured's SS#: _____

In Case Of Emergency Contact: _____ Relationship: _____

Phone: _____Address: _____

(Note: Your Emergency Contact does not have access to your medical information unless they are added to the HIPAA Form)

Preferred Pharmacy: _____Location:_____

Source of Referral to Our Office: _____

OUTPATIENT ASSIGNMENT OF BENEFITS and OTHER CHARGES

I hereby assign payment to Senior Care Systems, P.A. or any physician rendering service.

I authorize Senior Care Systems, P.A. and any physician rendering service to release medical records or other information which may be necessary for completion of insurance claims. I understand that I am financially responsible for all charges not paid by my insurance company. Senior Care Systems, P.A. files health insurance claims, but cannot guarantee insurance payments.

I also understand that even though I may have insurance (including Medicare), I am financially responsible for "copayments", "deductibles", "non-covered item" and any other charges denied by my insurer.

I understand that my account will be charged a $25 fee for any returned check. I also understand that Senior Care Systems, P.A. may charge me a $25 fee if I fail to show up for a scheduled appointment.

_____ _____
Patient's Signature (Or responsible party/POA, guardian, etc) Date

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Relationship to patient if signed by anyone other than the patient:_____

Patient's Name: _____ Today's Date: ____/____/____

Occupation: _____ Retired: YES NO Date of Birth: ____/____/____

Allergies & Reactions (drugs, food, environment): _____

Habits: Smoking: type/amount/how long: _____/_____/_____

Exercise (type/frequency): _____/_____

Alcohol (amount per week): _____ Caffeine (type/amount): _____/_____

Drug Use (type/amount): _____/_____

Living Will: YES NO HIV Risks Factors: _____

Medications & **Vitamins / Strength / Frequency**	**Hospitalizations** & **Surgeries** with **Dates**
_____/_____/_____	_____ ____/____/____
_____/_____/_____	_____ ____/____/____
_____/_____/_____	_____ ____/____/____
_____/_____/_____	_____ ____/____/____
_____/_____/_____	_____ ____/____/____
_____/_____/_____	_____ ____/____/____

(please attach a separate sheet of paper if needed)

Latest Vaccines and Test Dates:

Tetanus: _____ Flu: _____ Hepatitis B: _____ COVID: 1) _____ 2) _____ 3) _____

TB Test: _____ Pneumonia: 23: _____ 13:_____ Shingles Vaccine: _____

Last Eye Exam: ____/____/____ Last Bone Density: ____/____/____ Last Colonoscopy: ____/____/____ Normal: YES NO

Past Medical History:

Have you **EVER** had:

	Yes	**No**		**Yes**	**No**		**Yes**	**No**
Chicken Pox			Anemia			Prostate Disease		
Pneumonia			Seizures			Ulcer		
Rheumatic Fever			Headaches			Hepatitis		
High Cholesterol			Arthritis			Blood Transfusion		
Stroke			Fractures			Kidney Disease		
Heart Disease			Diabetes			Thyroid Disease		
High Blood Pressure			Cancer			Bleeding Tendencies		
Mitral Valve Prolapse			Asthma			Depression		
Tuberculosis			Emphysema			Glaucoma		

Has any blood relative EVER had:

	Relationship		**Relationship**
Cancer		Epilepsy	
Diabetes		Anemia	
Heart Disease		Bleeding Tendencies	
Stroke		Tuberculosis	
Hypertension		Other:	

Females: Gynecologist: _____

Last Pap test: _____/_____/_____ Last Mammogram: _____/_____/_____

Menstrual Flow: ___ Regular ___ Irregular ___ Menopause Type of Birth Control:_____

Number of Pregnancies: _____ Abortions: _____ Miscarriages: _____

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RELEASE OF PAST MEDICAL INFORMATION FOR PRIMARY CARE

I _____ hereby authorize and request that _____
(Patient Name) (Previous Physician/Practice Name)

in _____, _____, _____disclose to Health Partners the
(City) (State) (Phone)

identity, diagnosis, treatment and prognosis of all conditions on the items listed below during the period of the **last two years seen in your office**.

The information disclosed may include:

____ History and Physical

____ Radiology Reports

____ Laboratory Reports

____ Electrocardiogram

____ Immunization Record

____ Other Information _____

____ All of the above

I understand that this authorization is considered valid for 180 days and is revocable at any time up to the extent to which action has been taken. Written revocation is required.

_____ _____
Signature of Patient or POA Date

_____ _____
Address Telephone

_____ _____
Social Security Number Date of Birth

FOR HEALTH PARTNERS USE ONLY:

Date release faxed to physician: _____ By: _____

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PATIENT ACKNOWLEDGEMENT

Patient Acknowledgement of understanding of Senior Care Systems, P.A. Privacy Practices.

Patient Name: _____ Date of Birth: _____

SS#: _____ Previous Name: _____

I understand that a patient's health information is private and confidential. I understand that Senior Care Systems, P.A. works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Senior Care Systems, P.A. may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. Examples would be if a patient threatened to hurt someone or if required by a court order.

Senior Care Systems, P.A. has a detailed document called the "Notice of Privacy Practices." It contains more information about the policies and practices protecting the patient's privacy and is attached to this Acknowledgement. I understand that I have the right to read and request a personal copy of the "Notice" before signing this Acknowledgement.

Senior Care Systems, P.A. may update this Acknowledgement and "Notice of Privacy Practices." If I ask, Senior Care Systems, P.A. will provide me with the most current "Notice of Privacy Practices."

Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but are not limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specific methods or to an alternative location.

Senior Care Systems, P.A. has established procedures which help us meet our obligations to patients. These procedures may include other signature requirements, written acknowledgements, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs, etc. I will assist Senior Care Systems, P.A. by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices."

My signature below indicated that I have been given the chance to review a current copy of Senior Care Systems, P.A.'s "Notice of Privacy Practices."

_____ _____

Patient's Signature (Or responsible party/POA, guardian, etc) Date

Relationship to patient if signed by anyone other than the patient:_____

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AUTHORIZATION FOR USE/RELEASE OF HEALTH INFORMATION (HIPAA Form)

(This form applies only to the release and disclosure of information. It is not consent for treatment or intended for any other purpose)

Health Partners is committed to protecting our patients' privacy. Therefore, we will only release medical information to the individual(s) you list below. We understand that you may wish others to have access to only portions of your medical records and ask that you refer these individuals to the designated person(s) you list on this form. By doing so, you will help insure that we only release appropriate information to authorized individuals.

By signing this form, I authorize Health Partners, a division of Senior Care Systems, P.A., to release or disclose my protected health information to the following individual(s) (please write **NONE** if you do not wish us to release medical information to any individual):

Name: _____

Relation to Patient: _____

Phone: _____

Address: _____

Name: _____

Relation to Patient: _____

Phone: _____

Address: _____

The following information should not be released to anyone:

_____

PATIENT AUTHORIZATION FOR NOTIFICATION

I give the office of Health Partners, a division of Senior Care Systems, P.A., permission to contact me regarding appointment reminders, lab results and physician orders including prescriptions.

Please contact me at the following number: _____

You may leave a message at the above telephone number: ☐ YES ☐ NO
(I understand that this means some of my Personal Health Information will be released in this message.)

I have been offered a copy of Senior Care Systems, P.A.'s Notice of Privacy Practices and any charges that may be associated with this authorization. I have discussed any concerns I may have about the use, release, or disclosure of my health information with Senior Care Systems, P.A.'s Privacy Officer or other appropriate office personnel.

I understand that Senior Care Systems, P.A. assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release Senior Care Systems, P.A. from all legal liability that may arise from this authorization.

_____ _____
Patient's Signature (Or responsible party/POA, guardian, etc) Date

_____ _____
Patient's SS# Patient's DOB

If the signature above is not the patient's signature, please complete below:

My relationship to the patient is: _____Signature: _____

The patient or their representative may revoke this authorization by notifying Senior Care Systems, P.A.'s designated Privacy Officer in writing. Federal law states that treatment, payment enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the Privacy Rule. Federal law also requires a statement that there is the potential for the protected health information released under this authorization may be subject to redisclosure by the recipient.