

Insurance Company:

Member ID #

Reason for first visit?

To establish care

Need meds refilled

Other _____

Acceptance of Financial Responsibility: I understand that I am responsible for all medical expenses regardless of insurance coverage and whether or not there is an accident with another at fault. Also, if there is a workplace injury and the Workers Compensation carrier denies payment, I understand that I am responsible for these charges.

Authorization to Release Information: I hereby authorize Denton Healthcare to release any information acquired in the course of my examination or treatment to my insurance company, Workers Compensation or their representative.

HIPPA Medical Information Protection: I hereby authorize Denton Healthcare to receive and disclose any personal health information for my healthcare needs. By signing this form, I authorize Denton Healthcare to use and disclose my protected health information in accordance with established HIPPA guidelines. I also acknowledge that a copy of this privacy practices are on display and have been made available to me if I so desire.

Date

Signature (Patient/Parent of Patient)

Current or Past Medical Problems

- | | | |
|--|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mental Health Issues |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Goiter | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Neck Problems |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hepatitis A B C D | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Hernia | <input type="checkbox"/> Prostate Disease |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Depression | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Drug Dependency | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Ulcers |

Family Medical History

Mom: Alive Deceased Medical Problems: _____

Dad: Alive Deceased Medical Problems: _____

Brother: Alive Deceased Medical Problems: _____

Sister: Alive Deceased Medical Problems: _____

Other Family Medical History _____

Social History

Do you Smoke or Vape? _____ If yes which one and how much per day? _____

Do you Dip or Chew? _____ If yes which one and how much per day? _____

Do you use any illegal drugs? _____ If yes what kind? _____

Do you Drink Alcohol? _____ If yes how much? _____

Do you eat healthy? _____

Do you exercise? _____ If yes how much? _____

Do you have a Smoker detector in your home? _____

Do you wear a seat belt in the car? _____

Are you Single, Married, Separated, Divorced, Widowed? _____

I have reviewed DHC's HIPAA statement.

We will protect your medical records and other personal health information in accordance to the US Federal Statute.

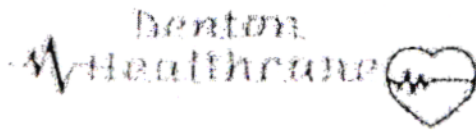
I give consent to DHC to retrieve and use my medication history from Sure Scripts.

I give consent to DHC to electronically query and retrieve my medical records for treatment purposes from all available sources.

I give DHC permission to use this in place of my electronic signature, and may initial on behalf of myself, and is valid as long as I am a patient.

Signature _____

Date _____



18539 S NC HWY 109
Denton, NC 27239
(P) 336-859-5001
(F) 336-859-1952

~~~~NO SHOW POLICY~~~~

If your schedule changes and you can not keep your appointment, please contact us so we may reschedule you, and accommodate those patients waiting for an appointment.

As a courtesy to our office as well as to those patients who are waiting to schedule with the physician, please give us at a 24 hours' notice.

If you do not cancel or reschedule your appointment with us at least a 24 hours' notice, you will be assessed a **\$25 "no-show"** service charge to your account. This charge is not reimbursable by your insurance company, and you will be billed directly for it.

After three consecutive "no shows" to your scheduled appointment, our practice may decide to terminate its relationship with you.

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Payment is expected at time of service.
All balances owed must be paid prior to next visit, or payment arrangements made before scheduling an appointment.

Date: _____

Signature: _____

DENTON HEALTHCARE 18539 S NC HWY 109, DENTON, NC 27239 (P) 336-859-5001 (F) 336-859-1952
AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ Date of Birth: _____
Phone: H) _____ Phone: W) _____
Address: _____ City/State/Zip: _____

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ Facility Phone: _____
Facility Address: _____ Facility Fax: _____
City, ST, Zip: _____

Dates and Type of Information to disclose:

- 2 years prior from last date seen
 Dates Other: _____
 Specific Information Requested: _____

The purpose of disclosure is:

- Change of Insurance or Physician
 Continuation of Care (e.g., VA Med Ctr)
 Referral
 Other: _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: DENTON HEALTHCARE
Address: 18539 S NC HWY 109
City, State, Zip: DENTON, NC 27239 Please mail records.
Fax: 336-859-1952 Phone: 336-859-5001 Please fax records.

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition:** _____
If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X _____
Signature of Patient / Parent / Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status.)

_____ Date

_____ Printed name of Authorized Representative

_____ Relationship / Capacity to patient

_____ Address and telephone number of authorized representative

