Cox Family Practice, PC 350 N. Cox Street, Suite 28 Asheboro, NC 27203

Kirsten S. Cox, MD Sally Davis, PA-C Andi Johnson, PA-C Lawrence E. Perry, MD

Registration

PATIENT'S PERSONAL INFO:

Marital Status: _____ Race: _____ Ethnicity: _____ Preferred Language: _____

Name: _____ Date of Birth: ____/____/_____
Last First M.I

Sex: M/ F S.S. #: _____-_____-_____ Driver's License #: _____*Please present your ID to front staff.

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____ Work Phone: _____-_____-_____

Address: _____ Apt#: ___ City: _____ State: ____ Zip: _____

Email: _____

Preferred Primary Care Provider (please circle one): Dr. Kirsten Cox Sally Davis, PA-C Andi Johnson, PA-C Dr. Lawrence Perry

EMERGENCY CONTACT: Name: _____ Phone: ____-____-_____ Relationship: _____

PREFERRED PHARMACY: _____

PATIENT'S/RESPONSIBLE PARTY INFO: Relationship to patient: __ Self __ Spouse __ Child __ Other: _____

Name: _____ Date of Birth: ____/____/_____
Last First M.I
Sex: M/ F S.S. #: ____-____-_____ Driver's License #: _____ Phone: ____-____-_____

Address: _____ Apt#: ___ City: _____ State: ____ Zip: _____

PATIENT'S INSURANCE INFO: *Please present your insurance card(s) to front staff.

Relationship to patient: __ Self __ Spouse __ Child __ Other: _____

1. Primary Insurance Name: _____ Effective Date: _____

Address: _____ Apt#: ___ City: _____ State: ____ Zip: _____

Name of Insured: _____ Date of Birth: ____/____/_____

Policy #: _____ Group #: _____ Co-pay: $_____

2. Secondary Insurance Name: _____ Effective Date: _____

Address: _____ Apt#: ___ City: _____ State: ____ Zip: _____

Name of Insured: _____ Date of Birth: ____/____/_____

Policy #: _____ Group #: _____ Co-pay: $_____

Assignment of Benefits – Financial Agreement:

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Cox Family Practice, PC, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date: ____/____/_____

Patient's signature (or authorized representative): _____

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Health Information Portability and Accountability Act (HIPAA)

Patient Name: _____ Date of Birth: ____/____/_____

Please indicate below how you wish this office to contact you:

___ Home # _____ ___ Cell # _____

___ Work # _____ ___ Other # _____

Does this office have permission to leave a voicemail at any of the above phone numbers regarding your treatment or other private health information? _____ Yes _____ No

If no, where would you like us to contact you with test results or other medical related issues?

_____

Please provide the name(s) below of any person we may communicate with regarding your private health information:

Name	**Relationship to you**	**Phone #**
_____	_____	_____
_____	_____	_____
_____	_____	_____

I was provided with the Notice of Privacy Practices from Cox Family Practice and hereby give my permission to the practice to communicate my private health information as instructed above.

Date: ____/____/_____

Patient's Signature (or authorized representative): _____

Phone: 336-629-6500 **Fax: 336-629-9500**

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Authorization to Release Healthcare Information

Patient Name: _____ Date of Birth: ____/____/____ S.S. #: ____-____-_____

I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand I may revoke this authorization except to the extent that action has been taken based on this authorization. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned upon my authorization of this disclosure. This authorization may include information related to ALCOHOL/DRUG ABUSE, MENTAL HEALTH, AND CONFIDENTIAL HIV RELATED INFORMATION only if I place my initials on the appropriate line. I request and authorize the listed persons/facilities to release healthcare information of the patient above to Cox Family Practice, PC.

Requested Medical Facilities:

1. _____ Fax: _____
2. _____ Fax: _____
3. _____ Fax: _____
4. _____ Fax: _____

This request applies to:

_____ All healthcare information

_____ Healthcare information dating to the following treatment, condition, or dates
From: ____/____/____ to ____/____/____

_____ Other _____

_____ Yes _____ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the facility listed above will be notified that I must give specific written permission before disclosure of this testing to anyone.
_____ Yes _____ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the facility above.

Patient's Signature: _____ Date: ____/____/_____

***Please send all requested information as soon as possible.**
Records can be faxed, mailed, or sent via disk. This request expires 365 days after it is signed.

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NOTICE OF USE OF HEALTH INFORMATION PRACTICE

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

1. Cox Family Practice may use and disclose protected health information for treatment, payment, and healthcare operations. Examples of these include, but are not limited to, requested preschool, or sports physicals, referral to nursing homes, foster care homes, home health agencies and/or referral to pother providers for treatment. Payment examples include but are not limited to, insurance companies for claims including coordination of benefits with other insurers; collection agencies. Healthcare operations include, but are not limited to, internal quality control and assurance including auditing of records.
2. Cox Family Practice is permitted or required to use or disclose protected health information without the individual's written consent or authorization in certain circumstances. Two examples of such are for public health requirements or court orders.
3. An authorization from the patient is required for uses or disclosures for marketing purposes and for disclosure constituting the sale of protected health information. No other use or disclosure of a patient's protected health information will be made without the individual's written authorization. Such authorization may be revoked at any time. Revocation must be written.
4. Patients have the right to opt out of any communication involving fundraising. In the event of a breach of unsecured protected health information, a notification will be provided.
5. Cox Family Practice will abide by the terms of this notice currently in effect at the time of the disclosure.
6. Cox Family Practice reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information that it maintains. Cox Family Practice will provide each patient with a copy of any revisions of its Notice of Information Practices at the time of their next visit, or at their last known address if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at our offices.
7. Any patient, guardian, or personal representative has the right to object to the use of their health information for directory purposes.
8. Any patient, guardian, or personal representative has the right to request to inspect and obtain copies of their medical record.
9. Any patient, guardian, or personal representative has the right to request amendments be made to their medical record.
10. Any patient, guardian, or personal representative has the right to request a six year accounting of all disclosures of their medical record. The history will be provided within 60 days of the request and a reasonable charge may be assessed for any copies after the first requested in a 12-month period.
11. Any patient, guardian, or personal representative has the right to request restrictions as to how their health information may be used or disclosed to carry out treatment, payment, or healthcare operations. The Practice is not required to agree to the restrictions requested except for a request for a restriction on a disclosure to a health plan where services have been paid in full, out-of-pocket, but if the Practice does agree, the Practice must abide by those restrictions.
12. Any person/patient may file a complaint to the Practice and to the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with the Practice, please contact the Privacy Officer at the following address and/or phone number: 350 N. Cox St, Suite 28, Asheboro, NC 27203, telephone: 336-629-6500 and fax: 336-629-9500. All complaints will be addressed and the results will be reported to the Privacy Officer.
13. It is the policy of Cox Family Practice that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.

Name of Patient: _____ **Date of Birth:** _____

Signature of Patient of Legal Guardian: _____ _____ **Date:** _____

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CONSENT FORM

(For Use and Disclosure of Protected Health Information (PHI) for Treatment, Payment, or Healthcare Operations)

I understand that as part of my healthcare, Cox Family Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care and treatment. I also understand this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand the Practice reserves the right to change their notice and practices, and prior to implementation, will mail a copy of any revised notice to the address that I have provided if there is a need to use or disclose any protected health information. I also understand that I have the right to restrict as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the Practice is not required to agree to the restrictions requested other than the exception noted in the Notice of Information Practices. I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon.

With this consent, Cox Family Practice may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With this consent, Cox Family Practice may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders and other correspondence as long as they are marked Personal and Confidential.

With this consent, Cox Family Practice may e-mail to me appointment reminders and patient statements. I have the right to request that Cox Family Practice restricts how it uses or discloses my PHI to carry out TPO. However, the Practice is not required to agree to my requested restrictions except for a request for a restriction on a disclosure to a health plan where services have been paid in full, out-of-pocket, but if it does, it is bound by this agreement.

By signing this form, I am consenting for Cox Family Practice to use and disclose my PHI to carry out my TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

If I do not sign this consent, Cox Family Practice may decline to provide treatment to me.

Patient Name: _____ **Date of Birth: _____**

Signature of Patient of Legal Guardian: _____ **Date: _____**

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HEALTH INFORMATION FOR YOUR PHYSICIAN

FULL NAME: _____ **DATE OF BIRTH:** _____

List all medications or substances to which you are allergic: _____

List all medications and herbal supplements you currently take: (if extra space is needed, please use back of sheet).

_____

PAST MEDICAL HISTORY: (Please circle illnesses or conditions you currently have or have had)

Diabetes	Abnormal Heart Rhythm	GI Bleeding	Seizures
Congestive Heart Failure	Hypertension	Kidney Stones	Depression
Stroke	Asthma	Kidney Failure	Stomach Ulcers
Heart Attack	COPD/Chronic Bronchitis	Thyroid Disease	Hepatitis A-B-C
Elevated Cholesterol	Diverticulitis	Bleeding Disorder	Arthritis
Abnormal Heart Valve	Heartburn/Reflux	Migraine Headache	Other: _____

Any type(s) of Cancer? If yes, what type & location: _____

Please circle and give dates of surgeries you have had:

Gallbladder	Bladder	Open Heart Bypass Surgery
Prostate	Colon Surgery	Thyroid Surgery
Appendectomy	Balloon Angioplasty	Total Hysterectomy
Mastectomy	Hernia	Partial Hysterectomy

Other: _____

Other than the above listed surgeries, list other previous hospitalizations below:

Date: **Reason:**

_____ _____

_____ _____

Last Mammogram: _____ Last Colonoscopy: _____ Last Physical: _____ Last Pap Smear: _____

Vaccines (Year): Pneumonia: _____ Flu: _____ Shingles: _____ Tetanus: _____ (Please provide vaccine records for minors).

Do you have advanced directives (living will, power of attorney) established? No Yes (if you'd like information, please ask).

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Have you ever had a blood transfusion? No Yes If so, when? _____

Have you ever lived or traveled outside the US or Canada? No Yes If so, where? _____

FAMILY HISTORY:	**Living**	**Age/Age of Death**	**Health Problems/Cause of Death**
Father	Yes___ No ___	_____	_____
Mother	Yes___ No ___	_____	_____
Brothers	Number Living: _____		Health: _____
	Number Deceased: _____		Cause: _____
Sisters	Number Living: _____		Health: _____
	Number Deceased: _____		Cause: _____

Please circle any illnesses that have occurred with any of your blood relatives:

Diabetes	Heart Attack	Congestive Heart Failure	Migraine Headaches
Stroke	Asthma	Kidney Failure	Seizures
Hypertension	COPD/Chronic Bronchitis	Thyroid Disease	Mental Disorders
Elevated Cholesterol	Bleeding Disorder	Abnormal Heart Rhythm	Arthritis

Cancers: _____

SOCIAL HISTORY: Occupation: _____ Employer: _____

Marital Status: Single Married Widowed Separated Divorced If married, how long? _____

Children: (Name and Age) _____

Smoking history: Cigarettes ___ Cigars ___ Pipe ___ How much? _____ How long? _____

Alcohol history: Beer ___ Wine ___ Mixed drinks ___ How much? _____ How long? _____

Do you use or have you ever used illegal drugs now or in the past? Yes___ No ___

If yes, explain: _____

**OTHER

Patient Name: _____ Date of Birth: _____

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INFORMED CONSENT FOR PATIENT PORTAL

Patient Name: _____ Date of Birth: _____

Email Address: _____

Purpose of the Informed Consent Form:

Cox Family Practice, PC offers a secure way for you to view parts of your medical record upon request, view normal laboratory results, update personal information, and receive clinical summaries. Secure patient portals do have certain risks. In order to manage these risks, there are certain conditions of participation. This form's intention is to document that you have been informed and accept the risks and the conditions of participation.

How to participate in the patient portal:

The patient portal occurs via a website hosted by our electronic health records system. Once you agree to and sign, you will be sent a welcome email which will give you a username and password to sign in. because of the security of the website, all information passing between the electronic medical record and your computer is encrypted so that it will remain secure. The patient portal can be accessed through our website http://www.coxfamilypractice.com or http://www.gotomyclinic.com/coxfamilypractice.

Protecting your private healthcare information and risks:

The security of the patient portal requires two things: the correct email address and the correct person (or the person authorized by that individual) having access to the email. These two factors are the responsibility of the patient. Please notify our office or the portal if you change your email address. You must also be very careful to keep track of who has access to your email account so only you or someone designated by you can read your portal messages. If you have any concern that someone else has your password, contact our office and we will issue you a new password. We understand the importance of privacy in patient care and will continue to strive to make all information as confidential as possible. We will never sell or give away any private information, including your email address.

Conditions of participating in the portal:

Access to and participation is optional and does not affect the care you will receive at Cox Family Practice. Therefore, we reserve the right to suspend or terminate this service at any time for any reason. If we do terminate the service, we will notify you as promptly as possible. You also agree not to hold Cox Family Practice or any of its staff liable for any network infractions beyond its control.

By signing below you acknowledge that you have read this consent form, and that you understand and will comply with it.

Signature of Patient of Legal Guardian: _____ Date: _____

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Cox Family Practice Pre-appointment Questionnaire

Name: _____ Today's Date: _____ DOB: _____

To help us get the most out of today's visit, please answer the following questions:

1. What is your main purpose in coming in today? (If you have a new complaint, indicate how long it has been present, what it feels like, what makes it better or worse, and what you are concerned the problem might be).

   _____

   _____

2. Are you experiencing any of the following symptoms *in relation to your main concern?* (Answer "yes" by circling the appropriate symptom).
   Constitutional symptoms: *fever, weight loss, extreme fatigue*
   Eyes: *double vision, sudden loss of vision*
   Ears, nose, mouth, and throat: *sore throat, runny nose, ear pain*
   Cardiovascular: *chest pain, palpitations*
   Respiratory: *cough, wheezing, shortness of breath*
   Gastrointestinal: *nausea, vomiting, abdominal pain, constipation, diarrhea, blood in stools*
   Genitourinary: *irregular menses, vaginal bleeding after menopause, frequent or painful urination, bloody urine, impotence*
   Skin: *rash, changing moles*
   Neurological: *headache, persistent weakness or numbness on one side of the body, falling*
   Musculoskeletal: *joint pain, muscle weakness*
   Psychiatric: *depression, anxiety, in the last 2 weeks have you lost interest or pleasure in doing things?*
   Endocrine: *excessive thirst, cold or heat in tolerance*
3. Has anything new come up in your family history? (Any of your blood relatives recently developed a new illness?) Yes / No (list below) _____
4. Have you been newly diagnosed with anything since your last visit to Cox Family Practice? _____
5. How much tobacco do you smoke or chew per day? _____
6. How much alcohol do you drink per week? _____

PE: _____
GEN: _____
HEENT: _____
NECK: _____
PULM: _____
CV: _____
GI: _____
LYMPH: _____
MS: _____
SKIN: _____
NEURO: _____
PSYCH: _____
OTHER: _____

A/P: _____

Signature: _____

Phone: 336-629-6500 **Fax: 336-629-9500**