CAPE FEAR VALLEY HEALTH

David A. Goodman, M.D.
FACS, FRCS (England)
Board Certified

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Your appointment with our office is scheduled for

_____

Please read over and complete the enclosed documents for your visit with our Physician. These documents must be completed and returned at the time of your appointment.

If one of our Physicians has treated you previously, please notify us.

It is important that all of your information be available to our physician to properly assess you at the time of your visit. Please have with you all documentation for your visit. These documents should include: x-ray and ultrasound films, lab work and any studies that may be useful.
FAILURE TO BRING THESE DOCUMENTS MAY RESULT IN YOUR APPOINTMENT BEING RESCHEDULED.

We look forward to seeing you. If you have any questions or concerns prior to your visit, please feel free to contact our office.

IF YOU ARE UNABLE TO KEEP YOUR SCHEDULED APPOINTMENT, WE ASK THAT YOU CONTACT OUR OFFICE AT LEAST TWENTY-FOUR HOURS PRIOR TO AVOID A NO SHOW CHARGE OF $25.00

We are located at 4140 Ferncreek Drive Suite 601. You can reach our office from Raeford Road. Turn onto Ferncreek Drive across from the old Ryan's Steakhouse. We are located in building 600, the last brick building in the plaza on the right.

Ferncreek General Surgery

4140 Ferncreek Drive
Suite 601
Fayetteville, NC 28314
(910) 485-3880
Fax (910) 485-5341

CFV-FERNCREEK GENERAL SURGERY

NEW PATIENT INTAKE SHEET

PATIENT INFORMATION

Name (First, M.I., Last):_____ SSN#_____ M F

Address:_____ Date of Birth:_____ Age:_____

_____ Phone#_____ Work#_____

Employer:_____ Driver's License#/State:_____

Employers Address:_____ Marital Status: S M W D

Referring Physician:_____ If Student, School name:_____

EMERGENCY CONTACT AND PHONE NUMBER:_____

E-MAIL ADDRESS:_____

RESPONSIBLE PARTY/GUARANTOR INFORMATION

NOTE: If patient is the responsible party/guarantor, enter "SELF" and go to Insurance Information

Name(First, M.I.,Last):_____ SSN#_____ M F

Address:_____ Date of Birth:_____ Age:_____

_____ Phone #_____ Work#_____

Employer:_____ Drivers License#/State:_____

Employer's Address:_____ Relationship to Patient:_____

INSURANCE INFORMATION

NOTE: IF YOU HAVE YOUR CARD(S) AND YOU ARE THE PATIENT, YOU MAY SKIP THIS SECTION

Payer/Insurance Name:_____

Address:_____

Policy Holder's Name:_____ SSN#_____ M F

Certificate#_____ Group#_____

Relationship to Patient Self Spouse Parent Date of Birth_____

Policy Holder's Employer and Address:_____

SECONDARY INSURANCE

Payer/Insurance Name:_____

Address:_____

Policy Holder's Name:_____ SSN#_____ M F

Certificate#_____ Group#_____

Relationship to Patient: Self Spouse Parent Date of Birth:_____

Policy Holder's Employer and Address:_____

PATIENT MEDICAL RECORDS RELEASE STATEMENT

I HEREBY ASSIGN, TRANSFER, AND SET OVER TO CFV-FERNCREEK GENERAL SURGERY all of my rights, title and interest to my medical reimbursement benefits under all of my insurance policies. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance. However, if CFV- Ferncreek General Surgery is in a direct contact with my third-party insurance payer, the financial responsibility provisions of the contract between my insurance payer and CFV-Ferncreek General Surgery will determine my ultimate financial responsibility.

I authorize CFV-Ferncreek General Surgery to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare or any other third-party payers. I authorize CFV-Ferncreek General Surgery to release all medical information to my referring physician and my primary (family) physician. I authorize CFV- Ferncreek General Surgery to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to CFV- Ferncreek General Surgery.

I authorize CFV-Ferncreek General Surgery to leave messages on my phone machine regarding

☐ **Appointment reminders** ☐ **Financial obligations to CFV-Ferncreek General Surgery**

I agree that these provisions will remain in effect until I provide written revocation to CFV- Ferncreek General Surgery.
I have received the HIPAA Notice of Privacy Policies for CFV- Ferncreek General Surgery.

Patient Signature: Date:

Responsible Party/Guarantor (if applicable) Date:

CFV—FERNCREEK GENERAL SURGERY – FINANCIAL POLICY

The physicians of CFV-Ferncreek General Surgery are committed to providing you with the highest level of quality medical care and personal service. The expense involved in providing this care is considerable, and in order to be able to continue to be of service to you and others it is necessary to ask that all patients and/or responsible parties meet their financial obligations associated with their care.

Because we see patients with many different types of medical coverage and insurance plans, it is impossible for us to be familiar with all the covered benefits, co-pays, and deductibles for every patient. Although we are here to assist you, it is still your responsibility to ensure that all services rendered to you by CFV-Ferncreek General Surgery are paid in full.

Payment at time of service is required. . We accept cash, check and Visa/MasterCard credit payments. Payment plans are provided by Cape Fear Valley Health System.

Patients with private medical insurance coverage. We have contracts with several insurance companies, and if your plan is one of these we can bill the company directly. In this situation, there may be a contractual discount on the charge to the company for services. If we do not contract with your company then the full charge will apply. You may be asked to satisfy the account yourself and to later contact your insurance company to obtain reimbursement. **Your payment is required at the time of service.**

Co-payments and deductibles. Co-payments and deductibles **are** amounts that your insurance plan requires us to **collect** from you **at the time of service.** You pay your insurance company a lower premium because you have a co-pay or deductible. If you do not pay your portion of the charges in full at the time of service then the balance, as stated on the encounter form you receive at the office, will be expected within 10 days. If you know that your deductible has not been met, or that your insurance company will not cover the service, we request that you notify us at the time of your visit. If we later receive payment from you insurance company, and discover that you have overpaid your portion of the charges, then we will gladly refund any overpayment.

Medicare patients. We participate with Medicare, which means we accept a greatly discounted amount for the services that we provide. Medicare will be billed for all covered services. For office visits **20% of the amount allowed** by Medicare for the visit is due from the patient and **will be collected at the time of service.** Medicare designates some services as non-covered, which means they will not pay for them. If you wish to receive such services you will be responsible for the full charge.

Medicaid patients. We participate with Medicaid, which means that we accept a greatly discounted amount for the services that we provide. Medicaid will be billed for all covered services. **Medicaid co-pays will be collected at the time of service.**

Patients without insurance coverage. Full payment at the time of service is required

Civil Suits, Auto, Home or Business Owners Claims. If you are involved in an accident or other suit and are seeking payment from the responsible party, **we expect payment at the time of service.** We do not bill the responsible party's insurance or attorney for your services due to the time it takes to settle these claims. Please do not request that we bill your regular health insurance in these cases, as the claims will be denied.

Returned Check. A $25.00 fee will be assessed to your account should we receive a returned check for insufficient funds or no account. You will be required to pick up the check and pay the full amount of the check plus the $25.00 fee with cash, money order or credit card.

Insurance Form Completion. We will be happy to complete relevant portions of insurance, FMLA, and social service forms, etc…for disability claims. Our standard fee for this is $10.00 per form.

Missed appointments. We allocate office time and staff for your scheduled appointment, and if you do not show then the time is wasted and could have been used for someone else. We therefore reserve the right to charge for missed appointments. We require advanced notice of at least one business day if you cannot make your scheduled appointment. If you fail to provide the required notice, we may charge a fee of $25.00 for each missed appointment.

By my signature below, I agree that I have read and understand the financial policy of CFV-Ferncreek General Surgery and further agree to hold harmless the physician's and staff of CFV-Ferncreek General Surgery for refusal to render further services in the event that I do not honor this agreement. I authorize CFV-Ferncreek General Surgery to submit medical claims for payment to my insurance carrier and other healthcare benefit associations. I assign all insurance and other healthcare benefits payable to CFV-Ferncreek General Surgery directly.

Responsible party_____ **Date:**_____

CFV-FERNCREEK GENERAL SURGERY
PATIENT HISTORY

This information is designed to aid the physician in understanding and assisting you with your condition. It is CONFIDENTIAL and will not be passed on to others without your consent.

NAME_____ DATE OF BIRTH_____AGE_____

OCCUPATION_____ SEX M F ETHNIC ORIGIN_____

MARITAL STATUS: SINGLEMARRIED SEPARATED DIVORCED WIDOWED

WHY ARE YOU SEEING THE DOCTOR TODAY?

_____

ALLERGIES

MEDICATIONS_____

_____

OTHER_____

_____

_____

CURRENT MEDICATIONS **THIS SECTION MUST BE FILLED OUT**

_____

_____

_____

_____

SMOKING NO YES HOW MUCH?_____

ALCOHOL NO YES HOW MUCH?_____

ILICIT DRIUG USE NO YES HOW MUCH?_____

WOMEN ONLY: Menstrual Periods: Age of Onset_____ Date of last Period_____

Regular Periods YES NO Age at Menopause_____

Pregnancies Number_____Children—How Many?_____

Age of Oldest Child _____ Did you Breastfeed? YES NO

PREVIOUS ILLNESSES_____

LIST DATES PLEASE _____

_____

_____

_____

PREVIOUS SURGERIES_____

LIST DATES PLEASE _____

_____

_____

_____

_____

_____

SIGNED_____ DATE_____

CFV-FERNCREEK GENERAL SURGERY
PATIENT HISTORY—PAGE 2

HAVE YOU HAD ANY OF THE FOLLOWING:

	YES	NO		YES	NO
WEIGHT LOSS			ACID REFLUX		
FEVER/CHILLS			DIFFICULTY SWALLOWING		
BLINDNESS			STOMACH ULCER		
DEAFNESS			BLEEDING FROM STOMACH		
CHRONIC COUGH			BLEEDING FROM RECTUM		
COUGHING BLOOD			CHRONIC DIARRHEA		
PROGRESSIVE VOICE LOSS			CHANGE IN BOWEL HABIT		
FREQUENT NOSEBLEEDS			HEPATITIS		
CHEST PAIN			YELLOW JAUNDICE		
HEART ATTACK			GALLSTONES		
ABNORMAL HEART RHYTHM			INFLAMED PANCREAS		
HEART VALVE DISEASE			APPENDECTOMY		
RHEUMATIC FEVER			KIDNEY/URINE INFECTION		
HEART MURMUR			KIDNEY STONE		
ENLARGED HEART			DIFFICULTY WITH URINATION		
ANGIOPLASTY			HYSTERECTOMY		
HIGH BLOOD PRESSURE			ARTHRITIS		
LEG PAIN WHEN WALKING			STROKE/PARALYSIS		
ANKLE SWELLING			SEIZURES		
EXCESSIVE SHORTNESS OF BREATH			BREAST LUMP		
PNEUMONIA			SKIN CANCER DIABETES		
TUBERCULOSOS			THYROID DISEASE		
ASTHMA			ANEMIA		
CHRONIC BRONCHITIS			BLEEDING DISORDER		
EMPHYSEMA			PHLEBITIS/BLOOD CLOTS		
HIV INFECTION					
CANCER			OTHER PROBLEMS	_____	

HAS ANYONE IN YOUR FAMILY HAD ANY OF THE FOLLOWING:

	YES	NO		YES	NO
HEART DISEASE			BREAST CANCER		
GALLSTONES			OVARIAN CANCER		
BLEEDING DISORDERS			LUNG CANCER		
PHLEBITIS/BLOOD CLOTS			STOMACH CANCER		
SICLE CELL DISEASE			COLON POLYPS/CANCER		
DIABETES					
			OTHER FAMILY PROBLEMS	_____	

PLEASE INDICATE THAT THE ABOVE IS ACCURATE AND TO THE BEST OF YOUR KNOWLEDGE BY SIGNING BELOW:

_____ SIGNED

_____ DATE

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REQUEST FOR RELEASE OF PATIENTS PRIVATE HEALTH INFORMATION

I, _____,
understand CFV-FERNCREEK GENERAL SURGERY is authorized by me to use, request or disclosure my protected health information for the purpose of treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I specifically authorize any current employee or owner of CFV-FERNCREEK GENERAL SURGERY, or any other individual employed with CFV-FERNCREEK GENERAL SURGERY to request, use and/or disclose my protected health information to the recipient listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so in writing to CFV-Ferncreek General Surgery.

Recipient Name and Address:

_____
_____
_____
_____

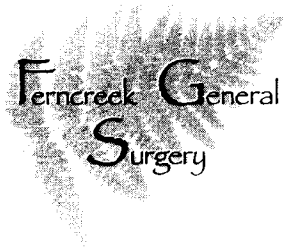
_____
PATIENT SIGNATURE

_____
DATE OF BIRTH

_____
SOCIAL SECURITY NUMBER

_____
WITNESS

_____
DATE



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