LifeLink Medical Group

901 Denim Drive, Erwin, NC 28339
Phone: 910-897-5521 * Fax: 910-897-2003
Md A Karim, MD * Sarah Stall, PA-C
Orlinda Martinez, PA-C * Ashley Irons, FNP-C

Patient Registration Form-Please Print

Patient Information

Name: _____ **Date of Birth**: _____ **Social Security Number**: _____

Mailing Address: _____ **City:** _____ **State**: _____ **Zip**: _____

Physical Address (if different): _____ **City:** _____ **State**: ____ **Zip**: _____

Home Phone ( ) _____ **Work Phone** ( ) _____ **Cell Phone** ( ) _____
****At which number may we leave a BRIEF OR EXTENDED MESSAGE?** _____

Email Address: _____ Circle **One: Single Married Widowed Separated Divorced**

Gender: Male Female Employer: _____ **Occupation**_____ **FT** _____ **PT**_____

Emergency Contact Name: _____ **Relationship to Patient**_____ **Phone**_____

How did you hear about us? _____

Circle One

Race: African American Caucasian Hispanic Asian American Native American Alaska Native Native Hawaiian

Ethnicity: Hispanic Non-Hispanic Language: English Spanish Other_____

Please Have Insurance Cards Present On Every Visit

Primary Insurance Name: _____ **ID#**_____
Sponsor/Subscriber Name: _____ **SS#**_____
Relationship to Patient: ___ **Self** ___**Spouse** ____**Parent** ____ **Other**

Secondary Insurance Name _____ **ID#** _____
Sponsor/Subscriber Name: _____ **SS#**_____
Relationship to Patient: ___ **Self** ___**Spouse** ____**Parent** ____ **Other**

Pharmacy

Local Pharmacy Name _____ **Phone#**_____
Address _____ **Fax #** _____

Mail Order Pharmacy name _____ **Fax** _____
Phone Number_____

Patient Signature _____ **Date:** _____

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We require 24 hour notice for the cancellation of all appointments or a no-show fee will be billed to you:

$25 for missed <u>Office Visits</u>

We have this policy in effect to try to minimize no-shows and keep our schedule open for patients in need.

I _____ have read, understand, and received a copy of the policies provided above.

Patient Signature _____ Date _____

Loss of Insurance/Uninsured Patients

If you should have a lapse in insurance coverage or loss of insurance WE DO ACCEPT NON-INSURED PATIENTS with the following guidelines:

- **Your bill must be paid in FULL at time of visit or your appointment will be rescheduled.**
- **Your first visit or regular follow visit will be $180.00 plus additional lab fees.**
- **In between visits will be $80.00, televisit is $50.00**

I _____understand and agree to the above guidelines.

Patient Signature:_____
Date: _____

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Medical History Form

Patient's Name _____ **DOB** _____ **Date**_____

What is the primary reason for your visit today?

_____

_____

Previous Primary Care Provider and Facility:

_____

_____

Other SPECIALIST (ex: Cardiology, Endocrinology)	
Provider Name:	**Provider Name:**
Phone:	**Phone:**
Location:	**Location:**
Provider Name:	**Provider Name:**
Phone:	**Phone:**
Location:	**Location:**

Pharmacy Information	
Preferred Pharmacy	**Secondary Pharmacy**
Name	Name
Address	Address
Phone	Phone

Advanced Directive - Mark any that apply

☐ None ☐ Living Will ☐ Do Not Resuscitate ☐ HC Proxy ☐ Durable Power of Attorney Date Reviewed:_____

Medication - List all medications you take, prescription and non-prescription, the dosage, and the frequency

☐ I do not take any medications

Medication Name	**Dosage (mg) and frequency (how often)**

Medication and Food Allergies - List all known allergies (dugs, food, animals, etc)	
⬜ No Known Allergies	
Allergy	**Reaction/Severity**

Medical History - Check if you have ever experienced the following conditions and the year it started.			
Condition	**Month/Year**	**Condition**	**Month/Year**
⬜ None		⬜ Gallbladder Disease	
⬜ Allergies		⬜ GERD (Acid Reflux)	
⬜ Anemia		⬜ Hepatitis; Type B or C?	
⬜ Angina (chest pain)		⬜ Hyperlipidemia (high cholesterol)	
⬜ Anxiety		⬜ Hypertension (high blood pressure)	
⬜ Arthritis		⬜ Irritable Bowel Disease	
⬜ Asthma		⬜ Liver Disease	
⬜ Atrial fibrillation		⬜ Migraine headaches	
⬜ Benign Prostatic Hypertrophy		⬜ Myocardial Infarction (heart attack)	
⬜ Blood clots		⬜ Osteoarthritis	
⬜ Cancer - Type:_____		⬜ Osteoporosis	
⬜ Cerebrovascular Accident (Stroke)		⬜ Peptic Ulcer Disease	
⬜ Coronary Artery Disease		⬜ Kidney Disease	
⬜ COPD (emphysema)		⬜ Seizure disorder	
⬜ Crohn's Disease		⬜ Thyroid Disease	
⬜ Depression		⬜ Other:	
⬜ Diabetes; Type 1 or 2?		⬜ Other:	

Health Maintenance - Chest if you have received the following and date of the most recent exam.			
Exam	**Month/Year**	**Exam**	**Month/Year**
☐ Most Recent Blood Work		☐ Physical Exam	
☐ Cardiac Stress Test		☐ PSA (prostate-specific antigen)	
☐ Colonoscopy		☐ Foot Exam	
☐ DEXA (Bone density) scan		☐ Pulmonary Function Test	
☐ Echocardiogram		☐ Other	
☐ EKG		☐ Other	
☐ Eye Exam		☐ Other	
Female Only	**Month/Year**	**Vaccinations**	**Month/Year**
☐ Mammogram		☐ Influenza Vaccine (Flu Shot)	
☐ PAP / Pelvic Exam		☐ Pneumococcal Vaccine	
☐ Colposcopy		☐ Shingles Vaccine	
Last of last menstrual period		☐ Tetanus Vaccine (Tdap)	
Duration of flow (days)		☐ COVID Vaccine	
Frequency of cycle			
If post menopausal, age at menopause			
Age at first child			
Age at menarche			
Current birth control method			
Total number of pregnancies			
Total number of living children			
Total number of miscarriages/abortions			

Family History - Check if any family member(s) has had any of the following conditions							
☐ I am adopted and have limited family history.							
Diagnosis	**Mother**	**Father**	**Brother**	**Sister**	**Other**	**Other**	**Other**
☐ Alcoholism							
☐ Allergies							
☐ Alzheimer's/Dementia							
☐ Asthma							
☐ Blood Clotting Disease							
☐ CAD (Heart Attack)							
☐ Cancer - Type							
☐ CVA (Stroke)							
☐ Depression							
☐ Diabetes							
☐ Eczema / Psoriasis							
☐ Hearing Deficiency							
☐ Hyperlipidemia							
☐ Hypertension							
☐ Irritable Bowel Disease							
☐ Kidney Disease							
☐ Learning Disability							
☐ Mental Illness							

⬜ Thyroid Disease							
⬜ Obesity							
⬜ Osteoarthritis							
⬜ Osteoporosis							
⬜ Rheumatoid arthritis / Lupus							
⬜ Vascular disease							
⬜ Other:							
⬜ Other:							

Surgical History - Check if you have received the following procedures and year it was performed.

Surgical Procedure	Month/Year	Surgical Procedure	Month/Year
⬜ None		**Male Only**	
⬜ Angioplasty		⬜ Prostate Biopsy	
⬜ Angioplasty with stent		⬜ TURP (Trans-urethral resection of prostate)	
⬜ Appendectomy			
⬜ Arthroscopy in Knee		⬜ Vasectomy	
⬜ Back surgery		⬜ Other:	
⬜ CABG (heart bypass)		⬜ Other:	
⬜ Carpal Tunnel Release			
⬜ Cataract Extraction		**Female Only**	**Month/Year**
⬜ Cholecystectomy		⬜ Augmentation Mammoplasty	
⬜ Colectomy		⬜ Bilateral Tubal Ligation	
⬜ Colostomy		⬜ Breast Biopsy	
⬜ Gastric Bypass		⬜ Cesarean Section	
⬜ Hernia Repair		⬜ Dilation and Curettage (D&C)	
⬜ Hip Replacement		⬜ Hysterectomy	
⬜ Knee Replacement		⬜ Mastectomy	
⬜ LASIK (eyes)		⬜ Myomectomy	
⬜ Liver Biopsy		⬜ Reduction Mammoplasty	
⬜ Pacemaker placement		⬜ Bilateral salpingo-oophorectomy (Removal of fallopian tube)	
⬜ Small Bowel Resection			
⬜ Thyroidectomy		⬜ Cervical biopsy	
⬜ Tonsillectomy		⬜ Other:	

Other Surgical Procedures	Month/Year	Other Surgical Procedures	Month/Year
⬜ Heart:		⬜	
⬜ Lungs:		⬜	
⬜ Ear / Nose / Throat:		⬜	
⬜ Abdomen:		⬜	
⬜ Orthopedic:		⬜	

Social History for Adult Patient		
Occupation	**Employer**	
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Life Partner		
Sexually Active? ☐ Yes ☐ No		
Do you have children? ☐ Yes ☐ No **How many?**		
Tobacco Use ☐ No ☐ Former	How many cigarettes per day? Age you start using tobacco: If former smoker, year quit?	☐ Cigarette ☐ Pipe ☐ Cigar ☐ Chewing ☐ Smokeless ☐ Vape
Alcohol Use ☐ No	☐ Daily ☐ Weekly ☐ Less ☐ Former / year quit:	☐ Beer ☐ Wine ☐ Liquor ☐ Other
Exercise Activity ☐ No	☐ Moderate ☐ Vigorous ☐ Sedentary Days per week of activity:	**Sleep pattern:** ☐ Changes ☐ No changes
Caffeine Use ☐ No	☐ Daily ☐ Weekly ☐ Less ☐ Former / year quit:	☐ Chocolate ☐ Coffee ☐ Soda ☐ Tea ☐ Tablets ☐ Other
Recreational Drugs ☐ No	☐ Daily ☐ Weekly ☐ Less ☐ Former / year quit:	Type:
Preferred Contact ☐ Mail ☐ Home Phone ☐ Cell phone ☐ Patient Portal		

Authorization to pay benefits to Physician

I hereby authorize payment directly to the physician of surgical and medical benefits, if any, otherwise payable to me for this service as described including Medicare Benefits. I understand that any balance on my account is due and payable by me, including any services rendered and not covered by my insurance carrier.

_____

Patient Signature **Date**

Medical Records Release Authorization

I hereby authorize Lifelink Medical Group to obtain and release any information, needed or obtained in the course of my treatment to physicians and/or medical providers where treatment is or may be rendered. I also hereby authorize my physician to release any information in the course of my treatment to process insurance claims.

Acknowledgement of Receipt of Notice of Office Policies of Lifelink Medical Group

The undersigned hereby acknowledges receipt of a copy of the Practices and Office Policies of Lifelink Medical Group.

_____

Patient Signature **Date**

Consent for Treatment

The undersigned hereby consents to medical services as may be deemed necessary by the Medical Providers at Lifelink Medical Group. The undersigned consents that Lifelink Medical Group, PLLC may obtain and use information from other healthcare providers such as pharmacies and hospitals.

_____

Patient Signature **Date**

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CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION TO FAMILY

I consent to disclosure of the following protected health information about me to the following family member(s) or person(s) involved in my care or payment for my care: _____, _____.
Name of person Name of person

Leave a message on my answering machine or voicemail___ yes ____ no
Mail medical information to my home address ____yes ____no
If no please give mailing address:_____

Check all that apply:

___ All my medical information
___ Information necessary to schedule appointments for me
___ Lab or test results
___ Information necessary to provide, call in or pick up prescriptions for me
___ Information necessary to help my family member(s) take care of me
___ Information necessary to allow my family member(s) to pick up or arrange for medical equipment to be provided for me
___ Information necessary to bill for or submit claims for care provided to me to government or private insurance payors

My consent will remain in effect as long as I am a patient of Lifelink Medical Group, unless and until I notify Lifelink Medical Group in writing of any changes.

_____ _____
Signature of Patient or Representative Date

_____ _____
Print Name Relationship or Representative to Patient

Although allowed under HIPPA, North Carolina law does not permit release of PHI outside of the Hospital unless required by law, pursuant to a court order or patient authorization, or for treatment, payment, or health care operations purposes as defined and limited by HIPAA. There is no exception for family members except for residents of a nursing home. The North Carolina physician-patient privilege statue, N.C.G.S. § 8-53, and HIPAA allow verbal authorization or consent for release, respectively, of information to family members. However, the better practice is to document the patient's consent in order to have clear evidence of the patient's intent. The package does not include a consent or authorization to release PHI to other providers or to insurance companies or others since most providers already have such forms. The contents of this form can be combined with such existing consent forms.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____	_____
PRINT PATIENT NAME	DATE OF BIRTH
_____	___**### - ## -**_____
STREET ADDRESS	SOCIAL SECURITY NUMBER
_____	_____
CITY, STATE, ZIP CODE	PRIMARY PHONE NUMBER

The above named patient authorizes _____ to release:

___All records from last 12 months ___ Radiology reports: dates _____

___All labs within last 12 months ___ Consultation notes: date _____

____ I DO ____ I DO NOT AUTHORIZE RELEASE OF INFORMATION RELATED TO AIDS (ACQUIRED IMMUNODEFICIENCY SYNDROME) OR HIV (HUMAN IMMUNODEFICIENCY VIRUS), INFECTION, PSYCHIATRIC CARE AND/OR PSYCHOLOGICAL ASSESSMENT AND TREATMENT FOR ALCOHOL AND/OR DRUG ABUSE

PLEASE RELEASE INFORMATION TO:

LifeLink Medical Group
901 Denim Drive, Erwin, NC 28339
Phone: (910) 897-5521 Fax: (910) 897-2003

PURPOSE OF DISCLOSER:

____CHANGE OF DOCTOR ____CONTINUING CARE ____OTHER (SPECIFY):

_____

I hereby authorize disclosure of the health information for the above patient. The authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class or facility receiving it and would no longer be protected by federal regulations.

SIGNATURE OF INDIVIDUAL/GUARDIAN:_____DATE: _____

Witness_____ Faxed by/date_____

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In order to better serve your needs and clarify any questions that you may have regarding your insurance, appointments, prescription refills, etc., we have adopted the following policies. Please take this information home with you to refer back to. If you have any questions, please speak with a member of the office staff and they will gladly assist you.

1. **Insurance filing and balance due:**
   -We will gladly file your insurance claim.
   -If we do not participate with your insurance company you will be responsible for payment in full the day of your appointment. We will then courtesy file your insurance claim for you and any reimbursement will be sent to you.
   -Co-payments are collected when you check-in. If you are unable to pay your co-pay we will reschedule your appointment.
   -Medicaid patients must show their Medicaid card each visit. If you do not have your new card you will be asked to reschedule your appointment.
   -All insurance changes must be given to us at the time of service. If your insurance changes, and we are not notified, you will be responsible for all charges. We will not bill your insurance for any prior charges before the change notification.
   -In the event your health insurance plan determines a service to be "not covered" you will be responsible for the charge.
   -As a courtesy to you, insurance forms for services rendered will be completed by our office with your primary and secondary insurance carrier. We will not file third insurance, but will provide you with the information needed to do so yourself.

2. **Statement Procedure:**
   -We will mail a "statement" to the address you have provided once we receive payment from your insurance carrier. In the event that payment is not received from you within 30 days, a second "past due statement" will be mailed.

3. **Returned Check Fee:**
   -If your check is dishonored or returned for any reason, we will charge you an additional processing fee of $30.00.

4. **Prescription Refills:**
   -Ask your pharmacy to fax us a refill request at 910-897-2003 and allow 24-48 hours for all prescriptions request. Any controlled substance refills will require an office visit to obtain this prescription refill.
   -Bring all medications with you to each visit.

5. **Completion of Forms:**
   -Any forms not associated with reimbursement of a claim will be a $25.00 fee or more to the patient due prior to completion of forms. Some forms may require an office visit.

6. **Appointment cancellations or reschedules:**
   -We ask that you give us 24 hour notice if you need to cancel or reschedule an appointment. This will allow us to give the appointment to someone who may need it. There is a $25.00 charge for a missed office visit. This charge must be paid prior to your next appointment.

7. **Late appointments:**
   -If you are 15 minutes late or later for your scheduled appointment you may be asked to reschedule.

8. **Currently, none of the Lifelink Medical Group providers have hospital privileges. As a result, the hospital doctors will determine your care during any hospital admissions. While our providers cannot influence your medical care during a hospital stay, we will gladly schedule a hospital follow-up visit once you are discharged to discuss your concerns and continue medical care.**

9. **Patient-Provider Relationship**
   -Lifelink Medical Group recognizes that medical care is a mutual relationship between a patient and the provider(s). Both parties have the right to terminate at any time if the relationship is no longer in the patient's best interest.