Cary Medical Clinic, PC

☐*155 Parkway Office Court, Suite 201 Cary, NC 27518 / Phone: 919.233.2022 / Fax: 919.233.2212*
☐*6402 McCrimmon Parkway, Suite 200 Morrisville, NC 27560 / Phone 919.655.0202 / Fax: 919.655.0203*

Patient Information

Full Name (**Last, First, M**)	Address:
	City:
Birth Date: Age:	State: Zip:
Sex: ☐ Male ☐ Female	**Primary Phone:**
SSN:	Home Phone:
Email:	Mobile Phone:
Preferred Language:	Work Phone:
Marital Status: ***Please Check One*** ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced	
Employment Status:	Emergency Contact:
Employer:	Emergency Contact Number:
	Relationship of Emergency Contact
Race: ***Please Check one*** ☐ American Indian/ Alaskan Native ☐ Asian ☐ Black or African American ☐ Other Pacific Islander ☐ Other Race ☐ White or Caucasian	
Ethnicity: ***Please Check One*** ☐ Hispanic or Latino ☐ Non-Hispanic ☐ Other Race	

Insurance Information

Primary Insurance	Secondary Insurance
Member ID:	Member ID:
Group Number:	Group Number:
If policyholder is different from patient:	
Name:	Name:
DOB: Sex: ☐M ☐F	DOB: Sex: ☐M ☐F
Relationship to patient:	Relationship to patient:

Financial Agreement and Authorization for Treatment

I authorize the treatment of the person named above and agree to pay all fees and charges for such treatment. I understand that Cary Medical Clinic will make all attempts possible to collect from my current insurance carrier as long as correct insurance cards are presented BEFORE treatment. After 120 days, I may receive a bill if my insurance does not respond. **I also understand that Cary Medical Clinic requires a 24-hour cancellation notice for a scheduled appointment and reserves the right to charge me if I do not show up/cancel the scheduled appointment.**

Signature_____ Date _____

Consent

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance not paid by my insurance. I also authorize Cary Medical Clinic to release any PHI (Protected Health Information) to my insurance company that is required to process claims.

Signature_____ Date _____

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New Patient Medical History

Name	Birth Date
Occupation	Education
Reason for Visit	Pharmacy

Past Medical & Family History

(Check off all that apply)

	Self	Mother	Father	Grandma/Grandpa (maternal)	Grandma/Grandpa (paternal)	Siblings
Hypertension						
Hyperlipidemia						
Hypothyroidism						
Diabetes						
Epilepsy/Convulsions						
Migraines/Headaches						
Heart Attack/Stroke						
Asthma/COPD						
Heart Valve Disorder						
Stomach Problems						
Neurological						
Arthritis						
Osteoporosis						
Cancer						
Anemia						
Mental Illness						
Depression						
Skin Problems						
Hair Loss						
Other						

Current Medications

Medication	Dose	Times/Day

Drug Allergies

Drug	Reaction

Hospitalizations/Surgeries

Illness/Operation	Year	Illness/Operation	Year

Social History

(Circle all that apply)

Tobacco Use	Yes	No	Pack/Day____Years____
Alcohol Use	Yes	No	Drinks_____
Exercise	Yes	No	Times a week_____
Marital Status			
Street Drugs	Yes	No	Type_____
Caffiene Use	Yes	No	Cups a Day_____
Pets	Yes	No	

For Women Only

(Circle all that apply)

Date Of Last Period		
Are you using Birthcontrol	Type:_____	
Number Of Pregnancies	1 2 3 4 5+	
Number Of Births	1 2 3 4 5+	
Number Of Abortions	1 2 3 4 5+	
Number Of Miscarriages	1 2 3 4 5+	
Pap Test	Date:_____	Normal/Abnormal
Mammogram	Date:_____	Normal/Abnormal

Last Time You Had A

(Most recent date&year)

Flu Vaccine	
Hepatitis Vaccine	
T.B. Test	
Tetanus Shot	
Pneumonia Shot	
Eye Exam	
Colonoscopy	

Other Specialists:

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Medical Records Release Authorization

Patient's Full Name _____ Date of Birth _____ /_____ /_____

Address_____

City_____ State _____ Zip_____

Phone _____ Email Address _____

By signing this form, I authorize the release of medical records:

FROM: Facility to Release Medical Records	**TO**: Party to Receive Medical Records
Name:	Name:
Address:	Address:
City/State/Zip:	City/State/Zip:
Phone #:	Phone #:
Fax #	**FAX #:**

Information to be released	**Purpose of Disclosure**
☐ Medical Records for the past 3 years	☐ Referral to Specialist
☐ Date(s) of Service: _____ to _____	☐ Insurance
☐ Radiology Reports	☐ Transfer of Care
☐ Laboratory Results	☐ Continuity of Care
☐ Cardiology Results	☐ Legal Investigation
☐ Operative/Procedure Reports	☐ Personal
☐ Behavioral/Mental Health Records	☐ Disability Determination
☐ Immunizations	☐ Other (specify)_____
☐ Other (specify): _____	

I understand that the records released may include sensitive information including mental health, substance use disorder, HIV/AIDS, communicable and sexually transmitted diseases, and genetic testing.

I understand that I may revoke this authorization at any time except for releases that have already been made. All releases will be handled discretely in compliance with HIPAA Patient Confidentiality guidelines for healthcare providers.

This authorization is valid one year from the date signed unless specified or revoked.

Signature of Patient or Patient Representative_____ Date _____

Printed Name _____ Relationship (if not signed by patient) _____

Witness (optional) _____ Date _____

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Dr. Neelu Agarwal Dr. Abhay Agarwal

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

Dear PATIENT,

As you may know as of April 14, 2003, Healthcare Providers are now required to uphold a Privacy Standard in order to protect your Private Health Information as it is used for treatment and payment for the treatment we provide for you. The Privacy Standard is named HIPAA: Health Information Portability & Accountability Act enacted in 1996 by President Clinton has now become a requirement for Healthcare Providers nationwide.

All we ask of you is to acknowledge that you have been presented with our notice of Privacy Practices posted in the waiting area, and specifically that Cary Medical Clinic, PC has been actively transitioning their work processes to meet the standards of privacy that are reasonable and efficient so as not to interfere with your treatment/ or payment for the treatment.

Any further questions or concerns can be directed to our Privacy Officer, Dr. Abhay Agarwal 919-655-0202.

Thank you for your cooperation with our Privacy Compliance.

Please sign below to Acknowledge Receipt:

Signature_____Date _____

CHART # _____

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Dr. Neelu Agarwal Dr. Abhay Agarwal

PATIENT RELEASE OF INFORMATION AUTHORIZATION FORM

Patient Name: _____ Date of Birth: _____

***In Accordance with HIPAA Compliance Regulation,* I authorize Cary Medical Clinic to disclose all my medical and financial information in reference to the inquiries of those persons (family or friends) listed herein. To add/or delete a person will be submitted by me in writing.**

Name	Relationship to Patient	Contact Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____

Patient Signature **Date**

PLEASE FILL THE PART BELOW IF YOU HAVE NOT LISTED ANYBODY ABOVE

I, _____ a patient of Cary Medical Clinic, do not wish to list any individuals for receipt of my medical and financial information at this time.

_____

Patient Signature Date

CHART # _____

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Dr. Neelu Agarwal Dr. Abhay Agarwal

PREVENTIVE VISIT AND LAB TEST POLICIES

While our office makes best efforts to check coverage for various labs, it is possible that your insurance may deny certain labs or apply the charges to your deductible based on your specific policy limitations.

If you have any questions on this, you must notify the doctor before getting the lab tests done. Once labs are done, you will be responsible for any lab-related charges, and our office staff **will not** be able to assist you with any lab-related bills.

We value your time, and we would like to help you make the most of your visit with us.

In an effort to prevent you from having to make multiple trips to our office, our providers are willing to perform both a preventive visit (also known as a CPE/biometric screening/Wellness Visit) and a problem–based visit (also known as an acute or chronic visit) during one office encounter if time permits.

Please be aware, however, that most insurance companies cover these services separately and independently. You may be asked to pay a co-pay and /or coinsurance for the portion of your visit dedicated to your acute or chronic medical condition(s). These charges will show up separately on your Explanation of Benefits from your insurance provider as an office visit charge and a preventive services charge for the same day.

Please let your provider know at the beginning of your visit if you have acute or chronic issues you would like addressed at the time of your preventive visit today so our time with you will be spent appropriately.

Patient Disclaimer

I have read the above description regarding billing for lab tests as well as for acute/chronic care in combination with a Complete Physical Exam (CPE) /Wellness Visit. I understand that if I choose to have my acute/chronic illnesses addressed during the same visit as my CPE/Wellness Visit I may be responsible for some portion of the bill as determined by the insurance policy I hold. I also understand that I have the right to schedule a separate appointment so that my acute/chronic illnesses can be thoroughly addressed on a different date of service. I further understand that any bills I receive from the lab company are my responsibility.

_____ _____

Patient Signature Date

CHART # _____