



**PATIENT INFORMATION**

**Patient Name:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

**Social Security Number:** (Last 4 Digits) \_\_\_\_\_ **Birth Date:** \_\_\_\_\_ **Gender:**  Male  Female

**Marital Status:**  Married  Single  Widowed  Divorced

**Home Address:** \_\_\_\_\_

**Phone Numbers:** **Primary** \_\_\_\_\_ **Work** \_\_\_\_\_ **Email** \_\_\_\_\_

**Preferred Language:**  English  Spanish  Other \_\_\_\_\_

**Race/Ethnicity:**  White/Caucasian  Black/African American  Asian  Hispanic/Latino  Other \_\_\_\_\_

**Emergency Contact Name:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**Whom may we thank for referring you?** \_\_\_\_\_

**EMPLOYMENT INFORMATION**

**Employer:** \_\_\_\_\_ **Position:** \_\_\_\_\_

**Employer's Address:** \_\_\_\_\_

**PREFERRED PHARMACY**

**Pharmacy Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Pharmacy Address:** \_\_\_\_\_

**INSURANCE INFORMATION**

**Responsible Party: If patient check here:**

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_ **Address:** \_\_\_\_\_

**Primary Insurance Co:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_

**Subscriber's Name:** \_\_\_\_\_ **ID Number:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_ **Ins. Phone Number** \_\_\_\_\_

**Secondary Insurance Co:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_

**Subscriber's Name:** \_\_\_\_\_ **ID Number:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Ins. Phone Number:** \_\_\_\_\_

**(PLEASE BRING YOUR INSURANCE CARD AND PHOTO ID TO ALL APPOINTMENTS)**



PIEDMONT  
INTERNAL  
MEDICINE

## Medical History Questionnaire

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

List main reason for today's visit: \_\_\_\_\_

\_\_\_\_\_

List any other active problems (include treating physician if applicable): \_\_\_\_\_

\_\_\_\_\_

Allergies and reaction: \_\_\_\_\_

Medications and dosages (please include supplements): \_\_\_\_\_

\_\_\_\_\_

Do you feel you have problems with sleep, snoring or day time sleepiness? \_\_\_ Yes \_\_\_ No

Would you like to speak with us about this? \_\_\_ Yes \_\_\_ No

Past medical illnesses (Please place a check by all which applies):

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Cancer          | <input type="checkbox"/> Heart murmur     | <input type="checkbox"/> STD(type)             |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Hepatitis B/C    | <input type="checkbox"/> Sickle cell disease   |
| <input type="checkbox"/> Aneurysm           | <input type="checkbox"/> COPD/Emphysema  | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Sleep apnea           |
| <input type="checkbox"/> Anxiety disorder   | <input type="checkbox"/> Depression      | <input type="checkbox"/> HIV              | <input type="checkbox"/> Stomach ulcer         |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Hypertension     | <input type="checkbox"/> Stroke                |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Glaucoma        | <input type="checkbox"/> Kidney disease   | <input type="checkbox"/> Thyroid disease       |
| <input type="checkbox"/> Blood disorder     | <input type="checkbox"/> Gout            | <input type="checkbox"/> Kidney stones    | <input type="checkbox"/> Tuberculosis          |
| <input type="checkbox"/> Blood clot         | <input type="checkbox"/> Hay fever       | <input type="checkbox"/> Liver disease    | <input type="checkbox"/> Positive TB skin test |
| <input type="checkbox"/> Blood transfusion  | <input type="checkbox"/> Heart disease   | <input type="checkbox"/> Seizure          | <input type="checkbox"/> Ulcerative colitis    |

\_\_\_ Other: (please specify) \_\_\_\_\_

Past Operations/Procedures and/or Hospitalizations (please include date): \_\_\_\_\_

\_\_\_\_\_

Family history (please indicate major medical problems; If deceased, please indicate cause of death):

Maternal Grandmother \_\_\_\_\_

Maternal Grandfather \_\_\_\_\_

Paternal Grandmother \_\_\_\_\_

Paternal Grandfather \_\_\_\_\_

Mother \_\_\_\_\_

Father \_\_\_\_\_  
 Siblings \_\_\_\_\_  
 Children \_\_\_\_\_

**Social History**

Occupation: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Children: \_\_\_\_\_  
 Alcohol Use: Yes\_\_ No\_\_ How often: \_\_\_\_\_ Quantity: \_\_\_\_\_  
 Tobacco Use: Yes\_\_ No\_\_ Pack per day: \_\_\_\_\_ How many Years: \_\_\_\_\_  
 Former Smoker: Yes\_\_ No\_\_ Pack per day: \_\_\_\_\_ Year quit: \_\_\_\_\_  
 Other Tobacco/Nicotine: Yes\_\_ No\_\_ Type: \_\_\_\_\_ Quantity: \_\_\_\_\_  
 Other Drugs: Yes\_\_ No\_\_ If yes, please specify: \_\_\_\_\_  
 Exposure to asbestos or other hazardous material: Yes\_\_ No\_\_ If yes, please specify: \_\_\_\_\_  
 Do you have a living will? Yes\_\_ No\_\_  
 Healthcare proxy: Yes\_\_ No\_\_ If yes, please indicate Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Health Maintenance**

Last known Menstrual cycle: \_\_\_\_\_ Last known Pap Smear: \_\_\_\_\_  
 Last known Mammogram: \_\_\_\_\_ Last known Colonoscopy: \_\_\_\_\_  
 Last known Prostate Cancer Screening: \_\_\_\_\_ Last Bone Density scan: \_\_\_\_\_

**Immunizations:**

Pneumonia: \_\_\_\_\_ Flu: \_\_\_\_\_ Tetanus/TD/Tdap: \_\_\_\_\_  
 Hepatitis A: \_\_\_\_\_ Hepatitis B: \_\_\_\_\_

**Review of Systems:** (Please place a check by all which applies):

	Weight Gain		Weakness		Insomnia		Blood in vomit
	Persistent Cough		Fainting		Mood Swings		Bowel Changes
	Blood in Stool		Frequent urination		Difficulty swallowing		Runny nose
	Headache		Tremor		Nausea		Feeling cold
	Weight loss		Fatigue		Change in vision		Back pain
	Fever		Change in exercise Tolerance		Vaginal discharge/bleeding		Blood in vomit
	Chest Comfort		Penis Discharge		Anxiety		Blood in sputum
	Difficult urinating		Breast pain		Change in hearing		Nipple discharge
	Memory Loss		Leg swelling		Depression		Short of breath
	Night Sweats		Pain with intercourse		Heartburn		Diarrhea
	Breast Lump		Trouble breathing		Skin rash		Nose bleed
	Leg pain		Palpitations		Feeling hot		Constipation
	Dizziness		Numbness/Tingling				

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reason Patient is Unable to Sign: \_\_\_\_\_ Date: \_\_\_\_\_



## PATIENT FINANCIAL AGREEMENT

Welcome to Piedmont Internal Medicine. We are dedicated to making sure that our patients are provided with exceptional medical care. **We strongly encourage each patient to contact their insurance company to confirm their doctor is a participating provider in their plan.**

As a service to our patients, we are currently enrolled in numerous Managed Care plans. However, it is impossible for the practice to know all the requirements of each individual plan. **It is the patient's responsibility to be aware of the parameters of your individual plan and to notify the office of any changes or restrictions.** Any charges which are accrued because of failure of notification will be the responsibility of the patient. If insurance cannot be verified prior to each appointment, payment will be due at the time of service.

Patients who have a HMO policy must ensure their physician is listed on their insurance card. If not, the insurance provider will not cover the services provided. Any unpaid charges will be the patient's responsibility.

At Piedmont Internal Medicine, PC we provide diagnostic procedures, examinations and medical treatment including laboratory work. As a courtesy, we file charges directly to your insurance. At times, it is required that we send medical records to assist with payment of these charges.

Please be aware some of the services billed to your insurance may result in charges to you depending on your individual insurance plan coverage. Please take the time to acquaint yourself with your insurance policy.

Please note Piedmont Internal Medicine, PC follows all Federal laws. We are not able to rebill due to services not being covered by your insurance policy. If you receive a bill from an outside facility such as LabCorp, Quest, or Piedmont Hospital, you will need to contact them directly.

Self-pay patients are required to pay at the time services are rendered. An initial deposit of 150.00 will be required at Check In. Upon check out charges will be reconciled. As a courtesy, Piedmont Internal Medicine, PC offers a self-pay rate on same date services provided, including most laboratory services, only if charges are paid the day of services.

We contact every patient to remind them of their appointment. We ask all patients to give at least 24 business hour advanced notice in canceling or rescheduling an appointment. Failure to do so will result in a fee of \$75.00 for an Office Visit, \$150.00 for a Physical Exam/Annual Wellness Visit and \$150.00 for an Echocardiogram. This will be your responsibility to pay.

Any **returned check** will incur a \$35.00 charge to cover bank charges associated with the returned check in addition to the amount of the check. NSF checks must be redeemed with certified funds and check will no longer be accepted as payment.

An upfront fee of \$35.00 will be collected for administrative tasks such as completing disability forms, FMLA, biometric screening form, medication prior authorizations and some medical records request. These tasks may require up to ten days to complete.

If any bills are acquired, it must be paid within 30 days of receipt. If you are unable to pay your balance, please contact the billing office to make payment arrangements. Any balance left unpaid nor under arrangements may be sent to a collection agency. If your account is sent to collections, there will be a \$30.00 collection fee added to the total outstanding balances.

**I acknowledge I have read and understand the policies above. I accept the rights and responsibilities outlined within them.**

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**PIEDMONT  
INTERNAL  
MEDICINE**

**CONSENT AND RELEASES**

**Consent for Treatment**

I, \_\_\_\_\_, hereby voluntarily consent to outpatient care at Piedmont Internal Medicine, PC encompassing routine diagnostic procedures, examination and medical treatment including, but not limited to, routine laboratory work (such as blood, urine, and other studies), and administration of medications prescribe by the physician.

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the physicians and their assistants, including nurse practitioners, physician assistants, medical assistants, or their designees as is necessary in the physician’s judgment.

Patient/Authorized Signature: \_\_\_\_\_ Date \_\_\_\_\_

If Patient is a Minor (under 18), Authorized Signature: \_\_\_\_\_

**Notice of Patient Privacy Consent (HIPAA)**

I have been provided with a copy (electronic and/or printed copy) of the practice’s Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information. (The Notice of Patient Privacy Consent is posted on our website at [www.PiedmontInternalMed.com](http://www.PiedmontInternalMed.com) for your convenience.)

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Authorized Release of Medical Information**

There are times where the physicians and employees of Piedmont Internal Medicine need to contact you. Our primary method is through our “My Chart” patient portal, however, circumstances may require us to contact you via email, telephone, voice mail, and/or text messaging. Please check the additional approved methods of how we may contact you regarding your personal and private health information. Please note, you may change or revoke your authorization approvals at any time. **Check all that apply:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Home Voice Mail/Answering Machine | <input type="checkbox"/> Text Message   | <input type="checkbox"/> Work Voice Mail |
| <input type="checkbox"/> Cell Phone Voice Mail             | <input type="checkbox"/> Personal Email | <input type="checkbox"/> Work Email      |
| <input type="checkbox"/> Other: _____                      |   |  |

I authorize the release of medical information to the following: \_\_\_\_\_

_____	_____
Name and Relationship	Name and Relationship

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Lifetime Medicare Authorization & Consent for Medicare Patients Only**

I certify that the information given by me in applying for payment under Title SVIII and /or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. Please note Federal Law requires us to collect your yearly deductible and co-insurance amounts. If you have a secondary insurance, we will bill your secondary insurance after Medicare pays the requested amount.

I understand that I am responsible for my health insurance deductibles and coinsurance.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Medigap Authorization Statement**

I authorize any holder or other information about me to release Piedmont Internal Medicine, P.C. any information needed for this or a related Medigap claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Consent for Use, Disclosure of Patient Information for the purposes of Treatment, Payment, and Healthcare Operations**

I hereby consent to Piedmont Internal Medicine, PC using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice’s health care operations. I also consent to Piedmont Internal Medicine, PC using or disclosing my protected health information for treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider or entity. I further consent to the disclosure of my protected health information in order for another provider or health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Health Information Exchange**

Health information exchange allows health care providers to share health care information about patients electronically for several purposes, such as treatment, quality assurance and state law reporting requirements. I understand that if I go to the Practice for treatment, the physicians and/or their staff may get a copy of my medication history and other health care information electronically through various health information exchange connections with other health care providers. **I understand I may request that my health care information not be shared through electronic health information exchange by following the directions in the Practice's Notice of Patient Privacy Practices.**

**Terminating Services**

All the providers and staff at Piedmont Internal Medicine value a meaningful and productive relationship with our patients. Unfortunately, there are occasions when this is no longer feasible. Please be advised that the Practice reserves the right to terminate the provider/patient relationship for the following reasons:

1. Multiple cancellations or missed appointments.
2. Medical Non-Compliance, including violation of Therapeutic Drug Agreement.
3. Failure to comply with practice policies, including yearly physical exams.
4. Rude, abusive behavior, use of obscene language, mistreatment of staff in person or on the phone.
5. Failure to pay a debt/account sent to collections

In such cases where the practice terminates the relationship, you will be notified in writing. Your provider will provide emergency medical care for 30 days following the date of the written notice, and will send medical records to your new provider with a written release. I have read and understand the reasons Piedmont Internal Medicine and my Provider may terminate the patient/provider relationship.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_