Aegis Medical Center
Internal Medicine

Patient Information

First _____ Middle Initial _____ Last _____

Prefers to be called _____ Date of Birth ___/___/___ Age ____ Marital Status _____

Address Primary _____ City _____ State_____ Zip _____

Phone #1 _____ Phone #2 _____ Phone #3 _____

Email Address _____

Preferred Method of contact: Letter Phone Call Email

Sex: F M Preferred Language _____ Race _____

Ethnicity _____ Occupation _____ Employer _____

Pharmacy

Pharmacy Name: _____

Pharmacy Location: _____

Pharmacy Phone Number: _____

Emergency Contact

Name _____ Phone # _____ Relationship to patient _____

I understand that when possible, Aegis Medical Center will file with my insurance for payment directly to the practice. I understand that I will be financially responsible for services NOT Covered by my insurance.

_____ _____

Signature of Patient/ Guardian Date

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Practice Policy

Aegis Medical Center is your home for medical care. We want you to consider us your home base for all medical care. We have implemented processes and procedures to partnership with you and your family and other healthcare professionals to provide the highest quality of coordinated care. As a practice we follow the guidelines of the American Board of Family Practice and provide the evidenced-based care.

HIPPA Notification
Our practice has implemented the Health Information Portability Act to protect the privacy of the patient health information.

Current Information
You are required to notify our staff of any changes in you patient information, such as insurance, benefits, employer, patient name, home address, email address and/or contact numbers. You will be ask to present your current insurance cards and your driver's license at each appointment.

Payment at Time of Service
If your insurance plan requires you to pay a co-payment, it will be collected during check-in. Patients that fail to bring their co-pay may be ask to reschedule their non-urgent appointment. If you are a self-pay payment or your insurance information cannot be verified prior to your appointment, you will be required to pay in full at the time of service. We accept cash, personal checks Master Card and Visa.
Your insurance cards and your drug/ pharmacy card must be present at each visit.

Claims Filing
As a courtesy to our patients, we file claims with your insurance company and also coordinate benefits with your secondary payers. You will be responsible for a timely payment in full of any patient balances as directed by your insurance. You will also be responsible in the event that the claim is disputed or unpaid.

Patient Billing and Collections
Patients that receive statements from our office are expected to remit a full payment upon receipt. If your account must be referred to an outside agency for non-payment, a fee will be added to your account to cover the expense incurred from the agency. **If you receive a billing statement that you do not understand, Please contact our billing coordinator so the issue can be resolved.**

After Hour calls
Our Practice provides after hours call for urgent calls. If the on-call provider is contacted and it is deemed "**Not an Emergency".** There may be a $35.00 charge added to the patients account. This is NOT reimbursed by your insurance company.

Late Policy
You have the responsibility to arrive at our office at your scheduled appointment time. Our practice reserves the right to reschedule patients that show up 15 minutes late for their appointment. If you are scheduled for a same day sick appointment, you are required to arrive on time.

Patient/ Guardian Signature _____ Date: _____

1000 Cresent Green, Suite 102, Cary, NC, 27518
P:919-233-0410 F:919-233-0872

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HIPAA Form

I, _____ understand that as part of my healthcare, Aegis Medical Center, originates and maintains electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for further care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communications among the many health professional that 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 health care operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand I have the right to request a copy of Aegis Medical Center Privacy Policies that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right of review the notice prior to signing this consent
- The right to object to use of my health information for directory purposes
- The right of request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations

I understand that Aegis Medical Center is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by section 164.506 of the Code Federal regulations.

I further understand that Aegis Medical Center reserves the right to change their notice and practices prior to implementation, in accordance with section 164.520 of the code of Federal Regulations. Should Aegis Medical Center, change their notice, they will send a copy of any revised notice to the address I have provided (whether US Mail or if I agreed, E-mail)

I authorize Aegis Medical Center to disclose my health information to:

Name _____ Relationship to Patient _____
Name _____ Relationship to Patient _____

I understand that as part of this organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity and I consent to such disclosure for these permitted uses, including disclosures via fax.

I full understand and ☐ accept or ☐ Decline the terms of this consent

Patient Signature _____ Date _____

Witness Signature _____ Date _____

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Cancellation Policy

Aegis Medical Center understands that occasionally you will be unable to attend your scheduled appointment. When this happens we kindly ask that you provide at least a 24 hour notice. This will enable us to offer that appointment time to another patient for that time slot. Missed appointment represent a cost to us, to you and to other patients who could have been seen at the time set aside for you. To assist you, Aegis Medical Center will try to confirm scheduled appointments. However, it remains the sole responsibility of the patient to keep their appointment.

Due to an increasing incidence of the number of scheduled appointments which are NOT Cancelled, Aegis Medical Center has had to follow other practices in the area and enact a written cancellation Policy.

We hope you understand that this is done with patient's best interests taken into account. We fell that this policy will continue to allow us to offer all of our patients same day sick appointments and more timely physical exams.

Therefore, please be advised that the following fees that the following fees will be charged when an appointment is missed without advance notice:

1st Appointment	Excused
2nd Appointment	$35.00
3rd Appointment	$50.00
Same Day Appointment	$25.00
Well visits/ Physicals	$45.00

After the 3rd missed appointment you will receive a warning letter. Aegis Medical Center reserves the right to dismiss from our practice any patients who consistently fails to meet this policy OR who refuses to sign this agreement.

I have read and understand the cancellation policy stated above and agree to accept responsibility as described.

_____ _____

Parent/ Responsible Party Signature Date

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Financial Policy

Co-Payments, Outstanding Balances and Fees

All co-payments, outstanding balances and fees for services not coved by your insurance policy are due at the time services are rendered. For any questions requiring coverage for any services/ treatments, we encourage you to contact your insurance carrier to review costs. As a convenience, we accept all major credit cards, debit cards, checks and cash.

Self- Pay

Patient without insurance coverage will be required to pay for all services at the time they are rendered. We do offer a discounted rate to Self-Pay Patients.

Returned Checks

A $35.00 fee will be charged on all returned checks. Additionally, we will no longer accept checks from you or any members of your family

Insurance collection

Your medical insurance policy is a contract between you and your insurance carrier and differs from individual to individual, even if from same insurance carrier. Our Providers should not be expected to know your individual insurance benefits or coverage amounts or terms and you should not take any opinion they may offer as fact. As a courtesy, we will bill your medical insurance carrier for services we provide. We will be diligent in making sure your insurance is filed accurately and promptly. It is your responsibility to ensure we have the most current copy of your insurance card, demographic and contact information. If your insurance cannot be verified at the time of service, you will be responsible for payment at time of service, you are responsible for any balance remaining after your insurance carrier has processed your claim (60-90 days). Should your insurance company reimburse us at a later date, we will gladly refund/ reimburse you.

Form Charges

We charge for the completion of several types of forms and correspondence will incur fees. Fees are strictly based on the amount of time required to fulfill your requests. Example Disability forms or Letters.
Charges for these services will range from $25 for a basic form, and vary depending on the amount of time required by the provider to complete the request.

Transfer of care

When transferring care to another provider, we will request and require you to close out any balances due. Charges for medical records will be calculated according to the North Carolina General Statutes. Payment is due at the time the records request is made.

After Hours

If the on-call physician is contacted after hours and is deemed NOT AN EMERGENCY, there will be a $35.00 charge added to the patients account. This is NOT reimbursed by your insurance.

Authorization

I agree to be responsible for my medical expenses regardless of insurance coverage; therefore, I authorize my insurance company, attorney, or other parties to pay directly Aegis Medical Center and/or provide any information regarding payment of my bill. If my account should become delinquent, I agree to pay all costs incurred in collecting the account, including a reasonable attorney's fee. I authorize the physicians in charge to administer medical care as necessary including the releases of medical information on my physical condition to any party involved in my treatment.

I have read, understood and agreed to the financial policy stated above, and I accept responsibility for any balance not covered by my insurance company.

_____ _____

Signature of individual/ Guardian Date

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PROTECTED HEALTH INFORMATION DESIGNATION FORM

I_____, give my permission for Aegis Medical Center to release any of the following information about my medical condition, financial account, and prescriptions as specified below:

Patient Contact Preference:

Phone Number_____ May leave detailed voicemail _____ YES _____NO

Email Address_____

Name and Phone Number of Person Name: _____ Phone Number: _____	Information to be Released ____Financial ____Medical Information ____Prescriptions
Name and Phone Number of Person Name: _____ Phone Number: _____	Information to be Released ____Financial ____Medical Information ____Prescriptions
Name and Phone Number of Person Name: _____ Phone Number: _____	Information to be Released ____Financial ____Medical Information ____Prescriptions

In case of a medical emergency or in cases otherwise permitted or required by law, written authorization will not be necessary. Please see Notice of Privacy Practices for additional details. You may make changes to your protected health information in writing at any time.

Patient Name:_____ Date of Birth_____

Signature: _____ Date: _____

Relationship, if other than the Patient: _____

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