Open Water Medical, PA

1620 C Live Oak St
Beaufort, NC 28516
Phone (252) 728-5737
Fax (252) 728-5739

3106 Arendell St
Morehead City, NC 28557
Phone (252) 808-2500
Fax (252) 808-2501

1209 E Ash St
Goldsboro, NC 27530
Phone (919) 734-9455
Fax (919) 734-4769

11 Office Park Dr
Jacksonville, NC 28546
Phone (910) 353-9906
Fax (910) 353-4853

263 Howard Blvd
Newport, NC 28570
Phone (252) 728-5737
Fax (252) 728-5739

Name: ____ ________ **Date Of Birth**: ________/_________/____________

Gender: M F **Social Security Number**: _______-_______-_______ **Marital Status**: S M W D Sep

Billing Address: ____

City: _____________________________ **State**: _______________ **Zip Code**: ______________________

Please specify if phone number is Cell, Home and/or work.

Phone: _______-_______-_________ C H W **Alternate phone: ________-__________-_________** C H W

Email address: ____

Employment status: Employed Student Retired Unemployed

Pharmacy (Please Specify Location): ____

Emergency Contact: ______________________________ Phone: ________-_________-________

Relationship: __________________________

Primary Insurance: _________________________________ Secondary Insurance: ___________________________

Primary Insurance Holder Name (if not patient): ___________________________Relationship: _________________

Policy Holder's Date of Birth: ______/_______/_________ Policy Holder's SSN: _______-________-________

<u>*Please provide receptionist with a copy of all Insurance Cards and Photo ID*</u>

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Signature: ____ Date: ____/______/________

I hereby authorize the practitioners of Open Water Medical, PA to apply for benefits on my behalf for covered services rendered to me. I request that payment from my insurance company be made directly to Open Water Medical, PA. I certify that the information I have reported with regard to my insurance coverage is correct. I permit the copy of this authorization to be used in place of the original.

Signature: ____ Date: ____/______/________

I have been informed and received a copy of the privacy policy in accordance to HIPPA regulations which briefly states that my information can only be given to those that I have provided to Open Water Medical, PA in writing.

Signature: ____ Date: ____/______/________

<u>Open Water Medical, PA</u>

<u>Notice of Privacy Practices</u>

Open Water Medical, PA is committed to protecting your privacy. As a healthcare provider, we know your trust in us is of central importance. This policy discloses our information use policies and practice in detail. Please read this document over to learn more about the ways we protect the information we collect. If Open Water Medical, PA changes it's information practices, we will provide you notice of any material changes.

- **<u>Strict security measures:</u>** Open Water Medical PA takes security of information very seriously and has established security standards and procedures to prevent unauthorized access to patient information. We maintain physical, electronic and procedural safeguards that comply with federal standards.
- **<u>Uses and disclosures of health information</u>**: We can use your health information and share it with other professionals who are treating you. We can use and share your health information to run our practice, improve your care, and contact you when necessary. We can use and share your health information to bill and get payment from health plans or other entities. We can share health information about you for certain situations such as: Preventing disease, Helping with product recalls, Reporting adverse reactions to medications, Reporting suspected abuse, neglect, or domestic violence and Preventing or reducing a serious threat to anyone's health or safety. We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- **<u>Individual rights</u>**: You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information. You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. If you request copies of your health information will charge a fee of $ 0.75 per page.
- **<u>Complaints</u>**: You can complain if you feel we have violated your rights by contacting the office. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting <u>ww.hhs.gov/ocr/privacy/hipaa/complaints/.</u> We will not retaliate against you for filing a complaint.
- **<u>Our legal duty:</u>** We are required by law to maintain the privacy and security of your protected health information, provide this notice of our information practices, and follow the information practices described in our notice.

For more information on health information you can go to: <u>www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html</u>

Print Name: ____ Date: _______/_________/________

Signature: ____

Open Water Medical

Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Many of our patients have questions regarding payment and insurance responsibility for services rendered; we have developed this payment policy. Please read it and ask us any questions you may have.

1) **Insurance:** We participate in most insurance plans, including Medicare. If you are not insured by a plan we take, payment in full is expected at each visit. If you are insured with a plan we take but don't have your insurance card payment is expected in full at each visit until your insurance can be verified. Please contact your insurance company with any questions.

2) **Proof of insurance:** All patients must complete our patient information before seeing a provider. We must obtain a copy of your photo ID and current valid insurance card to provide proof of insurance. Failure to provide this information in a timely manner could result in you being responsible for the balance of the claim.

3) **Co-payments and deductibles:** All copayments and deductibles must be paid at time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect payments and deductibles from patients and be considered fraud. Please help us in upholding the law by paying your copayment at each visit.

4) **Non-covered services:** Please be aware that some, and perhaps all, of the services provided may not be covered by insurance. If they deny services you must pay for the services in full.

5) **Claim Submission**: We will submit your claims and assist you in any way we can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.

6) **Coverage changes**: If your insurance changes please notify us before your next visit so we can make the appropriate changes to help your receive your maximum benefits. If your insurance does not pay the claim in 45 days, you will be responsible for the balance.

7) **Non-payment:** If your account is 90 days past due you will receive a letter that you have 20 days to pay your account in full. Partial payment/ payment arrangements will be accepted if negotiated with our billing department. Unpaid balances may be referred to a collection agency.

8) **Missed appointments:** If you are unable to make your appointment, please notify the office 24 hours in advance. Multiple missed appointments may be grounds for: $30 Missed Appointment Fee and/or dismissal from the practice.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature: ____ Date: ________/________/__________

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Kerry A. Willis, MD • W. Jack Orton, PA • Terri Turner, FNP

Michael H. Cartledge, PA • Robert Krause, MD

AUTHORIZATION TO RELEASE HEALTH INFORMATION

____ __________________

Patient Name Date of Birth

____ __________________

Telephone Social Security

Records to: **Open Water Medical, PA** Records From:

This information is being disclosed for the purpose of Continuing Health Care. Healthcare covering from __________ to __________.

Complete Heath Record to be disclosed or (check appropriate line)

History and Physical Exam ______ Progress Notes ______ Discharge Summary ______
X-Rays/ Ultrasounds ______ Laboratory Tests ______ Consults ______

I understand that specific information to be released may include AIDS and HIV, Alcohol and/or Drug Abuse, and Mental Health.

I understand that if I request Copies of records for myself or a member of my family, a review of this information with my physician or other healthcare provider is encouraged. I understand that if the physician does not feel if it is in my best interest, I may designate another provider to receive these records. I accept responsibility for these copies and information contained herein.

Unless otherwise indicated, this authorization will expire ninety (90) days from the date of signature. The physician and employees are released from any legal responsibility or liability or disclosure of the above information to the extent indicated and authorized herein. I understand that this authorization may be evoked in writing at anytime, except to the extent that action has been taken in reliance on this authorization for the purposes stated above.

I understand that there may be a fee for preparing and furnishing this information.

_______________________________ _____________________________ _____________

Signature of Patient or Legal Guardian Relationship to Patient Date

____ _____________

Signature of Witness Date

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HIPAA COMPLIANT MEDICAL AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

To whom it may concern:

I, ______________________________, ____
Name   Date of Birth

hereby authorize the release of all medical documentation and other information, including protected health information that I could personally obtain upon request, which may be in the possession of any health care provider, medical care facility, insurer, physician, hospital, ambulance service or nurse or any other covered entity under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA) to

__________________________________, ____
Name   Date of Birth, Phone Number, Relationship to Patient

__________________________________, ____
Name   Date of Birth, Phone Number, Relationship to Patient

Regarding my complete medical history and physical and mental condition both prior to and subsequent to the date of this authorization, regardless of lapsed time. The person(s) named above is/are hereby designated as my "personal representative(s)" as that term is used within HIPAA.

I intend the person(s) listed above to have the authority to gain immediate access to my medical records.

Upon presentation of this authorization (or a photocopy), you are authorized to release a copy of these records to any person who is my personal representative. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the personal representative and may no longer be protected by federal law.

The purpose of the disclosure is to enable the person(s) named above to fully act as my personal representative under HIPAA, including the ability to access and re-release my medical records. This authorization shall be deemed to comply with all requirements of HIPAA (45 CFR Section 164).This authorization shall become effective on the date it is signed and expire two years after my death. I understand that I may revoke this authorization at any time, without regard to my mental or physical condition, by sending written notice to my medical providers or by using any method capable of revoking a health care agency under Illinois law.

Signature of person authorizing disclosure:

____   ___________________
Signature of person authorizing disclosure   Date

Witnessed on the date Noted above by: ______________________________   ______________________________
Signature of Witness   Print name of Witness

Patient Name: ______________________________

Allergies	Reaction

Hematology:

☐ Anemia
☐ Blood Clots
☐ Hemophilia/Bleeding Disorders
Other: ________________________________

Bone & Joint:

☐ Fractures
☐ Gout
☐ Osteoarthritis
☐ Osteoporosis
☐ Psoriatic Arthritis
☐ Back Pain
☐ Joint Pain
☐ Rheumatoid Arthritis
Other: _____________________________

Endocrine:

☐ Diabetes
☐ Diabetic Peripheral Neuropathy
☐ Gallbladder disease
☐ Hyperthyroid
☐ Hypothyroid
☐ Liver disease
☐ Obesity
Other: _____________________________

Eye/Ear:

☐ Blindness
☐ Cataracts
☐ Deafness
☐ Glaucoma
☐ Dry Eye
☐ Hearing loss
☐ Macular Degeneration
☐ Tinnitus
Other: _________________________________

Sleep:

☐ Insomnia
☐ Fatigue/Daytime Sleepiness
☐ Narcolepsy
☐ Sleep Apnea
Other: ____________________

Infectious Disease:

☐ Hepatitis B/Hepatitis C
☐ HIV/AIDS
☐ Tuberculosis
Other: ____________________

Skin:

☐ Eczema
☐ Hives
☐ Psoriasis
☐ Rosacea
Other: ____________________________

Cardiac/Respiratory:

☐ Angina
☐ Arrhythmia
☐ High Cholesterol
☐ Hypertension
☐ COPD
☐ Congestive Heart Failure
☐ Mitral Valve Prolapse
☐ Heart Attack
☐ Coronary Artery Disease
☐ Peripheral Artery Disease
☐ Heart Murmur
☐ A-Fib
☐ Asthma
☐ Bronchitis/Emphysema
Other: ______________________________

Kidney/Urinary:

☐ Bladder infections
☐ UTI
☐ Urinary leaking
☐ Kidney stones
☐ Overactive Bladder
☐ Lupus Nephritis
Other: _________________________________

Women's Health:

☐ Endometriosis
☐ Fibroids
☐ Infertility
☐ Menopause
☐ PCOS
Other: ___________________________

Men's Health:

☐ Enlarged Prostate
☐ Erectile Dysfunction
☐ Low Testosterone
☐ Elevated PSA
Other_____________________

Mental Health:

- ☐ ADD/ADHD
- ☐ Bipolar Disorder
- ☐ Alzheimer's Disease
- ☐ Anxiety
- ☐ Depression
- ☐ PTSD
- ☐ Schizophrenia
- ☐ Eating Disorder (Specify):_________________

Other: ___________________________________

Neurological:

- ☐ Fibromyalgia
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Stroke
- ☐ TIA
- ☐ Parkinson's Disease
- ☐Seizures
- ☐ Huntington's Disease
- ☐ Traumatic Brain Injury

Other: ____________________________

Gastroenterology:

- ☐ Acid Reflux/GERD
- ☐ Celiac Disease
- ☐ Constipation
- ☐ Crohn's Disease
- ☐ Diverticulitis
- ☐ Ulcers
- ☐ IBS
- ☐ Lactose intolerance
- ☐ Colitis

Other: ______________________________

Cancer:

- ☐ Breast
- ☐ Colon
- ☐ Lung
- ☐ Ovarian
- ☐ Prostate
- ☐ Leukemia
- ☐ Bone

Other: __________________________

Current Medications:

Medication Name	Dose	Frequency

Surgical History

Surgery	Side (Left/ Right/Bilateral)	Date

Social History:

Current Smoker YES NO Packs Per day______________ **Other Tobacco Product: _______________**

Previous Smoker YES NO Date Quit: ________________ **Packs Per day________________**

***How many years have you smoked: ___________________?**

Alcohol Intake: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Recreational Drug Use: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Drugs Used: ____

Family Medical History:

	Mother	Father	Brother	Sister	Maternal Grandfather	Maternal Grandmother	Paternal Grandfather	Paternal Grandmother
Abdominal Aortic Aneurysm								
Alcoholism								
Cancer(Specify TYPE)								
Depression								
Diabetes								
Genetic Disorders								
Heart Disease								
High Blood Pressure								
High Cholesterol								
Kidney Disease								
Liver Disease								
Osteoporosis								
Obesity								
Stroke								

Have you have any of the following procedures:

Procedure	Date	Where
Mammogram		
Bone Density		
Colonoscopy		
Pap Smear / Pelvic Exam		
Physical / Wellness Exam		
EKG		
Echocardiogram / Stress Test		
Heart Catheterization		
AAA Screening		
Hepatitis C Screening		
PSA Labs		
Eye Exam		

Immunization History:

	Date	Where
Flu Shot		
Tetanus		
Pneumovax		
Prevnar 13		
Shingles		
COVID		