Welcome to Intracoastal Internal Medicine, PA

2580 Pickard Road, Wilmington, NC 28403
Ofc 910-332-0701 Fax 910-332-0710
www.intracoastalmedicine.com

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-pay amounts 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 new Medicaid card each month. 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 electronically debit your account for the amount of the check plus a $25 processing fee.**

4. **Prescription Refills:**
   - Ask your pharmacy to fax us a refill request at 910-332-0710. Allow 48 hours for completion of all prescription requests. **We do not take prescription requests through our after hours call center.**

5. **Completion of Forms and Obtaining Previous Medical Records:**
   - 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 the form(s).
   - Previous medical records can be requested on the patients behalf by completing our Release of Information form.

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 missed appointment charge of $25.00 for established patients and a $100 charge for new patients in which prior notice was not given.** This charge must be paid prior to your next appointment.

7. **Late Appointments:**
   - **<u>If you are 15 minutes late or later for your scheduled appointment you may be asked to reschedule.</u>**

8. **After hours care:**
   - Should you become ill after office hours you may call our office at 910-332-0701 and speak with our emergency call center or you may go to Medac Health Services at 4402 Shipyard Blvd. Medac will communicate with our on call provider and will fax your treatment notes to us. Medac is open daily from 8 am to 11 pm. ***Certain medical conditions should always be treated in an Emergency Department. Please call 911 or go directly to the Emergency Department if you are experiencing crushing chest pain, difficulty breathing, loss of consciousness or think you are having a stroke.***

9. **Hospitalization:**
   - If you require hospitalization then you will be referred to the hospitalist service at New Hanover Health Network. Once you are discharged from the hospital you will be scheduled for follow-up with our office. All of your records from the hospital will be available to us through our physician portal.

10. **Patient Portal:**
    - All you need is an email address. This service will allow you to send messages to your physician and the office, request refills, review your lab results, request appointments and review upcoming appointments, update your address and phone numbers and review your current billing statement. Allow 24 hours for your requests to be completed. If you have not activated your patient portal or have lost your login credentials notify our staff.

11. **Office Hours:**
    - The office is open Monday through Friday from 8 am to 5 pm.

12. **Walk-in Lab Hours:**
    - Our Walk in lab is available weekday mornings from 7:30 am to 11 am and weekday afternoons from 1:30 pm pm to 4 pm. Please come in a week prior to your scheduled appointment for your fasting lab work. Please remember this is a walk in lab and we will do our best to accommodate you in a timely manner.

13. **Telephone Directory:**

Appointments	1
Clinical Staff	2
Billing	3
Medical Records	4

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910-332-0701 fax 910-332-0710

Patient Registration Form – Please Print

Patient Information

Name _____

Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ Wk Phone (____) _____ Cell Phone (____) _____
** At which number may we leave a ***BRIEF or EXTENDED*** message? _____

Date of Birth _____ Social Security Number _____

Email Address _____

Circle One: Single Married Widowed Separated Divorced

Employer _____ FT _____ PT_____

Emergency Contact Name _____ Phone _____

Relationship to patient _____

Circle One:

Race: African American Caucasian Hispanic Asian American Indian Alaska Native
Native Hawaiian/Other Pacific Islander

Ethnicity: Hispanic Non-Hispanic

Language: English Spanish Other _____

Responsible Party

Relationship to Patient: _____ Self _____ Spouse _____ Parent _____ Other
Name _____
Address _____ City _____ State _____ Zip _____
Home Phone (____) _____ Wk Phone (____) _____ Cell Phone (____) _____
Date of Birth _____ Social Security Number _____

Pharmacies

Local Pharmacy Name _____
Location _____ Phone _____
Mail Order Pharmacy Name _____
Phone _____ Fax _____

Patient Signature _____ **Date** _____

INTRACOASTAL INTERNAL MEDICINE

PATIENT ACKNOWLEDGMENT AND CONSENT

For New Patients Only

I have been given a copy of Intracoastal Internal Medicine's Notice of Privacy Practices, version effective August 1, 2013. I consent to the uses and disclosures of my health information as outlined in the Notice.

_____ _____

Signature of Patient or Representative Date

_____

Print Name

_____

Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of Patient: _____

_____

_____

FOR INTRACOASTAL INTERNAL MEDICINE USE ONLY

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain acknowledgment and the reason you could not obtain it:

_____

_____

_____

_____

_____

Intracoastal Internal Medicine, PA
2580 Pickard Road
Wilmington, NC 28403
Phone: 910-332-0701 Fax: 910-332-0710

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 Intracoastal Internal Medicine, PA 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.

_____ _____

Patient Signature Date

Acknowledgement of Receipt of Notice of Office Policies of Intracoastal Internal Medicine

The undersigned hereby acknowledges receipt of a copy of the Practices and Office Policies of Intracoastal Internal Medicine.

_____ _____

Patient Signature Date

INTRACOASTAL INTERNAL MEDICINE
CONSENT FOR RELEASE OF

PROTECTED HEALTH INFORMATION TO FAMILY[1]

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:

_____
_____
_____
_____

Check all that may 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 Intracoastal Internal Medicine unless and until I notify Intracoastal Internal Medicine in writing of any changes.

_____ _____
Signature of Patient or Representative Date

_____
Print Name

_____
Relationship of Representative to Patient

[1] Although allowed under HIPAA, 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 statute, 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.

Intracoastal Internal Medicine Patient Review

Patient Printed Name: _____

Family History

Mother	O Coronary artery disease	O Hypertension	O Stroke	O Diabetes	O Cancer
Father	O Coronary artery disease	O Hypertension	O Stroke	O Diabetes	O Cancer
Sibling(s)	O Coronary Artery Disease	O Hypertension	O Stroke	O Diabetes	O Cancer

Review of Systems

FEMALE REPRODUCTIVE

Hot Flashes	O Yes O No	Pelvic Pain	O Yes O No
Nipple Discharge	O Yes O No	Irregular Menses	O Yes O No

PSYCHOLOGY

Depression	O Yes O No	Suicidal Ideation	O Yes O No
Anxiety	O Yes O No	Stressors	O Yes O No

MUSCULOSKELETAL

Muscle Aches	O Yes O No	Back Pain	O Yes O No
Joint Stiffness	O Yes O No	Joint Swelling	O Yes O No
Joint Pain	O Yes O No		

CONSTITUTIONAL

Weight Gain	O Yes O No	Weight Loss	O Yes O No
Fever or chills	O Yes O No		

ENT

Sinus Pain	O Yes O No	Ringing in Ears	O Yes O No
Post-nasal Drip	O Yes O No		

UROLOGY

Blood in Urine	O Yes O No	Difficulty urinating	O Yes O No
Urinary Incontinence	O Yes O No	Nighttime urination	O Yes O No

CARDIOLOGY

Chest Pain	O Yes O No	Palpitations	O Yes O No
Leg Edema	O Yes O No	Shortness of Breath	O Yes O No
Shortwinded reclining	O Yes O No	Irregular Heart Beat	O Yes O No

GASTROENTEROLOGY

Blood in Stool	O Yes O No	Diarrhea	O Yes O No
Constipation	O Yes O No	Heartburn	O Yes O No
Change in Bowels	O Yes O No		

DERMATOLOGY

Changing Mole	O Yes O No		

ENDOCRINOLOGY

Fatigue	O Yes O No	Cold/Heat Intolerance	O Yes O No

NEUROLOGY

Tingling/Numbness	O Yes O No	Weakness	O Yes O No
Headache	O Yes O No	Paralysis	O Yes O No

OPTHALMOLOGY

Eye Irritation	O Yes O No	Vision Loss	O Yes O No

RESPIRATORY

Chest Congestion	O Yes O No	Wheezing	O Yes O No
Coughing up blood	O Yes O No	Poor Circulation	O Yes O No

ALLERGY

Sneezing	O Yes O No		

HEMATOLOGY/LYMPH

Swollen Glands	O Yes O No		