HAZELWOOD
FAMILY MEDICINE
1088 Brown Avenue
Waynesville, NC 28786
828-456-2828

Welcome to our practice!

On behalf of our staff, we welcome you to Hazelwood Family Medicine. We are pleased that you have selected us to care for your health care needs and we look forward to your initial visit. We want you to know that we are committed to providing you with the highest quality of health care in the most efficient and enthusiastic manner possible. We pride ourselves on making your visit a pleasant experience, while providing you with the best treatment.

Attached you will find our new patient packet. Please complete and return to our office and we will schedule your first appointment. This appointment is required so that we may gather all pertinent information regarding your health care needs. We will also ask you to sign a records release form so we may attain your previous medical records. Please bring your current medications (prefer bottles) and a list of providers you have seen in the past 12 months.

Please be prepared to pay any copay's, deductibles, or coinsurance amounts required at time of service. These will be collected before your appointment. Please verify with your insurance carrier that we are in network with your carrier.

We appreciate the value of your time, and except for emergency situations, yu can expect us to be on time for you. Should you have any questions about our practice, services, or policies please do not hesitate to contact our office. We look forward to your visit.

Sincerely,

Hazelwood Family Medicine

Michael A. Brown, MD

Elizabeth K. Carmichael, FNP

Sarah J. Lipham. FNP

WELCOME

HAZELWOOD FAMILY MEDICINE
1088 Brown Avenue - Waynesville, NC 28786
Telephone: (828) 456-2828 - Fax: (828) 456-8903

1 PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____
City State Zip

Email _____

Sex: ❑ M ❑ F Age _____ Birthdate _____

❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Birthdate _____ SS# _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

Relationship _____ Date _____

MEDICARE

I request that payment of authorized Medicare benefits be made either to me on my behalf to Dr. _____ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature _____ Date _____

3 PHONE NUMBERS

Home _____ Work _____ Ext. _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone _____ Work Phone _____

4 FAMILY HISTORY

Date of last physical examination _____

What is your reason for visit? _____

ALIVE DECEASED	FATHER ❑ ❑	Present health or cause of death	MOTHER ❑ ❑	Present health or cause of death	SPOUSE ❑ ❑	Present health or cause of death

BROTHERS	NO. ALIVE	HEALTH	NO. DECEASED	CAUSE OF DEATH
SISTERS	NO. ALIVE	HEALTH	NO. DECEASED	CAUSE OF DEATH
CHILDREN	NO. ALIVE	HEALTH	NO. DECEASED	CAUSE OF DEATH

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR BLOOD RELATIVES ❑ Diabetes ❑ Cancer ❑ Bleeding tendency ❑ Kidney disease ❑ Tuberculosis ❑ Heart disease ❑ Stroke ❑ High Blood Pressure ❑ Nervous illness ❑ Allergy ❑ Other

-OVER-

5 MEDICAL HISTORY

All information is strictly confidential.

Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- ☐ Chills
- ☐ Depression / Nervousness
- ☐ Dizziness / Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High / low blood pressure
- ☐ Irregular / rapid heart beat
- ☐ Poor circulation
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gyms
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache / ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision - flashes / halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching / rash
- ☐ Change in moles
- ☐ Scars
- ☐ Sore that won't heal

MEN only

- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

Describe serious illnesses or operations _____

6 MEDICATIONS / ALLERGIES

List medications you are currently taking _____

_____

Pharmacy Name _____ Phone _____

List allergies to medications or substances _____

_____

_____

7 HEALTH HABITS

HEALTH HABITS Check (✓) which substances you use and describe how much you use.

- ☐ Caffeine _____
- ☐ Drugs _____
- ☐ Tobacco _____
- ☐ Other _____

OCCUPATIONAL Check (✓) if your work exposes you to the following:

- ☐ Stress
- ☐ Heavy Lifting
- ☐ Hazardous Substances
- ☐ Other _____

Your occupation _____

8 SIGNATURES

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his / her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____

Reviewed by _____ Date _____

Hazelwood Family Medicine Office Policies Effective January 1, 2017

Please keep this copy for future reference.

Appointments

All patients need to arrive 15 minutes early to complete any necessary forms and should provide proper insurance documentation. Patients should bring their current medications with them to each visit.

Appointment Requests – All return appointments are to be scheduled before leaving the practice if possible. All other appointment requests should be done through your patient portal. You may send all requests for an appointment to either one of our front desk schedulers. Please be sure to add your full name and Date of Birth under the Subject line and leave a detailed message.

Missed Appointments - Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late-cancelled appointments. Excessive missed appointments may result in discharge from the practice. You may cancel your appointment through your MyQuest Patient Portal by sending a direct message to either one of our front desk schedulers. Please be sure to add your full name and Date of Birth under the Subject line and leave a detailed message.

Receptionist/Front Desk

Christy stameyc@direct.care360.com Carrie C. CCOLE@direct.care360.com

Medical Records

The contents of your medical record will remain confidential and will be released only upon your written authorization. Please allow 7-14 business days for us to process your request. Medical records can be requested through your MyQuest patient portal by sending a request to our medical records clerk. Her direct email is srose.hfm@direct.care360.com

All other requests must be done at the front desk by signing a records release form. Please have the name, address, and fax number to the provider/clinic you wish to receive your records. Please be sure to add your full name and Date of Birth under the Subject line and leave a detailed message.

After Business Hours On-Call Providers

Please dial the main telephone number to reach the on-call staff at (828) 456-2828. The on-call line is for Urgent Care Only. Normal business hours 8:00 to 5:00 Monday through Thursday and 8:00 to 3:00 on Fridays. If you have a true Emergency after normal business hours, please DIAL 911. Leave a

detailed message and they will be in touch with you as soon as possible. Please do not leave requests for routine or controlled medication prescription requests, appointments or appointment cancellations

Lab Results

You may access your labs through your MyQuest Patient Portal. Once your provider has reviewed your labs, you may view, download and print for your records. Turnaround time is usually 2-3 days. Some labs take 7-10 days for completion. Your provider will review and provide instructions for you to review. Should you have any questions regarding your labs or instructions, please send a request for further information through your MyQuest Patient Portal. You may contact our Lab Tech through your MyQuest Patient Portal at dmcfalls.hfm@direct.care360.com. Please be sure to add your full name and Date of Birth under the Subject line and leave a detailed message.

Medication Refills and Requests

Please anticipate the need to have a prescription refilled and allow up to 72 hours for the prescription approval and processing. When a prescription needs to be refilled, please call your pharmacist. You may also request a refill through your Patient Portal at MyQuest.com. Please send a direct message to your provider's assistant. Medication requests done through the portal will have priority to phone requests. Your health record has the ability to save your preferred pharmacy, where all prescriptions will be sent. Please be sure to add your full name and Date of Birth under the Subject line and leave a detailed message including pharmacy name and location.

Michael Brown

Brittany bsmith134@direct.care360.com Carrie cmehaffey.hfm@direct.care360.com

Elizabeth Carmichael

Elisia esmith.hfm@direct.care360.com

Sarah Lipham

Lori kernl3@direct.care360.com

Routine prescriptions cannot be refilled evenings, weekends, and holidays. Please contact the office through you patient portal during weekdays and before any medication has completely run out.

* Narcotics and sedative medicines require a written prescription and will not be refilled after hours.

Prior Authorizations or Precerts

Should your medication or procedure need a prior authorization or precert, you may contact Deneen through your MyQuest Patient Portal at codyd@direct.care360.com. Most prior authorizations take 2-3 days for approval from your insurance. Please be sure to add your full name and Date of Birth under the Subject line and leave a detailed message.

Dismissals

Hazelwood Family Medicine reserves the right to dismiss any patient who is verbally or physically abusive, uncooperative with our providers or staff, or otherwise violates policies and procedures. If you are dismissed from our practice, you will be given a 30 day notice. After this notice is given, we will see

you for life-threatening emergencies only. No controlled substances will be prescribed.

Financial Arrangements and Payment Policy

Our physicians are dedicated to providing you with the highest quality medical care while maintaining cost efficiency.

Insurance - Insurance is a contract between the patient and the insurance company. Hazelwood Family Medicine is not a party to that contract. All balances are the patient's responsibility regardless of insurance coverage. Patients with insurance are responsible for any co-pays and deductibles (if not met) at check-in. As a courtesy, our office will file your primary, secondary and tertiary insurance. The patient is responsible for any remaining balance after the insurance payment if no payment is made from the insurance company within 60 days.

Proof of Insurance - You will be asked to show the receptionist your current insurance card at each visit. This allows us to verify the information and assist you in collecting the benefits from your insurance company to which you are entitled. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

Medicaid - Hazelwood Family Medicine is currently seeing adult Medicaid patients (age 16 and over) on a case by case basis. If no doctor is available please call us in a few months.

Self-pay (no insurance) - If you are not covered by medical insurance, your balance is due in full at the time of service. A $60.00 payment is due at check-in and the remaining balance due at checkout, unless prior arrangements have been made. If further lab tests or procedures are needed, you will be provided a cost before services are rendered. If you become eligible for Insurance we will be happy to file and refund you when they have paid.

Billing - Hazelwood Family Medicine sends three billing statements. After the first statement your balance is considered past due and you may be charged a billing fee of $2.50 on additional statements. If your past due balance is not addressed after your third billing statement our system will not allow us to schedule an appointment.

Payment Type - We accept cash, personal checks, Visa, MasterCard, debit cards and money orders. We do not accept third-party checks.

Diet, Cosmetic, and Suboxone Patients – Cash, Credit, or Debit Cards only.

Returned Checks - We will charge a fee of $30 for checks returned to us for insufficient funds. Future services will require payment by cash, debit card, credit card or money order.

Form Completion

Form completion requires specific information regarding the status of your health and takes time and resources to complete. Forms that need to be completed outside of an office visit will be prepared and you will be charged for preparation of forms. Please leave any forms you need completed with your physician and they will be happy to accommodate you.

MyQuest Patient Portal

Your MyQuest Patient Portal can be created and accessed by following this link.

https://myquest.questdiagnostics.com/web/home

Our office staff will send you an invitation to the portal. Please provide them with an email and they will generate your pin number to link your account to your provider. Once the link has been established, you will have direct access to your primary care provider's team. After you have created a MyQuest account, please add the attached direct messaging addresses to your contacts. This will allow you direct access to a member of our staff. (see attached)

With your MyQuest Patient Portal, you can store all your medical information in one location for easy access in the case of an emergency. Should you have any questions regarding the use of your MyQuest Portal, please refer to the help tab on the MyQuest homepage or you may contact a representative by calling 1-877-291-7521.

If you do not have internet access, please let one of our staff know so we can find the best alternate source for non-emergent issues.

MyQuest
by Care360

Connect with your doctor, anytime, anywhere using the MyQuest Patient Portal

Your doctor is now using the MyQuest Patient Portal from Quest Diagnostics, making it easier for you to manage your healthcare.

Using QuestDiagnostics.com/MyQuest

- Receive an electronic copy of your office visit notes, current medication list and lab results from your doctor
- View, download or print your medical information
- Send secure messages to your doctor any time of day
- Share your medical information with other doctors and family members *(requires a secure email account)*

Plus, MyQuest offers companion mobile apps for iPhones and Android which allow you to set medication reminders, store "In Case of Emergency" information and much more.

Please provide our front desk staff with your current email address and we will forward you your personal PIN to establish a secure connection. You may also request our front desk staff to generate your PIN at any visit.

Quest Diagnostics

Hazelwood Family Medicine
1088 Brown Ave
Waynesville, NC 28786
Phone: 828-456-2828 Fax: 828-456-8903

Michael A. Brown, MD
Elizabeth K. Carmichael, FNP
Sarah J. Lipham, FNP

AUTHORIZATION TO RELEASE MEDICAL RECORDS & HEALTH CARE INFORMATION

Patient's Name: _____ Date of Birth _____

Address _____ Telephone _____

City/ State/ Zip _____ Social Security # _____

I request and authorize release of medical information as indicated below:

FROM: Practice Name: _____
Address: _____
City/ State/ Zip: _____
Phone: _____ Fax: _____

TO: Practice Name _____
Address: _____
City/ State/ Zip _____
Phone: _____ Fax: _____

This request and authorization applies to:

☐ Health care information relating to the following treatment, condition, or dates: _____

☐ ALL health care information

☐ Other _____

I would like my records sent to the practice above: (choose one)

☐ Mail a copy of my records (NOTE: there is a $25 fee for hard copies or disks) ☐ Fax to _____

☐ Send record electronically (if capable) ☐ Pick up a copy of records

Purpose of request: ☐ For another doctor ☐ Patient request ☐ Use in a law suite
☐ Referral ☐ Patient transfer ☐ Other _____

I authorize the release of protected information related to my health care. The information authorized for release may also include mental health, drug/alcohol abuse treatment, and STD results both positive and negative. This category of medical information/ records is protected by Federal confidentiality rules (42 CFR Part 2). Federal rules prohibit anyone receiving this information or records from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient. As a result, by signing below, I specifically authorize any such records included in my health information to be released.

Patient's Name _____

Signature of Patient, Parent, or
Legally Authorized Representative _____ Date Signed _____

Updated 6/19/13

Hazelwood Family Medicine, PLLC

Michael A Brown, MD Elizabeth U. Carmichael, FNP Sarah J. Lipham, FNP

Release of Information

1. Please list the family member(s) or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and healthcare operations).

2. Please list the family member(s) or other persons, if any, whom we may inform about your medical condition ONLY IN CASE OF EMERGENCY.

3. Please print the address of where you would like your correspondence from our office to be sent if other than your home.

4. I give permission to Hazelwood Family Medicine, PLLC for the following:

   Leave messages on my answering machine or voicemail concerning appointments, other aspects of my medical care, and account issues.

   To leave messages with whomever answers the telephone at my house.

5. I understand that if I should need to change any of this information, I need to contact Hazelwood Family Medicine in writing of such changes.

Patient Name: Chart Number

Patient Signature Date

1088 Brown Avenue Waynesville, NC 28786 (828) 456-2828

The Patient Health Questionnaire-2 (PHQ-2) - Overview

The PHQ-2 inquires about the frequency of depressed mood and anhedonia over the past two weeks. The PHQ-2 includes the first two items of the PHQ-9.

- The purpose of the PHQ-2 is not to establish final a diagnosis or to monitor depression severity, but rather to screen for depression in a "first step" approach.
- Patients who screen positive should be further evaluated with the PHQ-9 to determine whether they meet criteria for a depressive disorder.

Clinical Utility

Reducing depression evaluation to two screening questions enhances routine inquiry about the most prevalent and treatable mental disorder in primary care.

Scoring

A PHQ-2 score ranges from 0-6. The authors[1] identified a PHQ-2 cutoff score of 3 as the optimal cut point for screening purposes and stated that a cut point of 2 would enhance sensitivity, whereas a cut point of 4 would improve specificity.

Psychometric Properties[1]

Major Depressive Disorder (7% prevalence)				Any Depressive Disorder (18% prevalence)			
PHQ-2 Score	Sensitivity	Specificity	Positive Predictive Value (PPV*)	PHQ-2 Score	Sensitivity	Specificity	Positive Predictive Value (PPV*)
1	97.6	59.2	15.4	1	90.6	65.4	36.9
2	92.7	73.7	21.1	2	82.1	80.4	48.3
3	**82.9**	**90.0**	**38.4**	**3**	**62.3**	**95.4**	**75.0**
4	73.2	93.3	45.5	4	50.9	97.9	81.2
5	53.7	96.8	56.4	5	31.1	98.7	84.6
6	26.8	99.4	78.6	6	12.3	99.8	92.9

** Because the PPV varies with the prevalence of depression, the PPV will be higher in settings with a higher prevalence of depression and lower in settings with a lower prevalence.*

1. *Kroenke K, Spitzer RL, Williams JB. The Patient Health Questionnaire-2: Validity of a Two-Item Depression Screener. Medical Care 2003, (41) 1284-1294.*

The Patient Health Questionnaire-2 (PHQ-2)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3