New Patient Request Form

Manuli Internal Medicine

104 Mill End Court, Elizabeth City, NC 27909

Phone (252)338-5183 Fax (252) 338-5669

Please complete form and return to us, **we will call you with an appointment**.

Name: _____ Date: _____

Phone: _____ Date of Birth: _____

Reason for appointment: _____

Insurance Coverage(s): _____

Provider Requested: **(Please select one)**

- o Mechell Smith, DNP, RN, NP-C
- o Thaddeus English, PA-C

Healthcare Providers seen in the past 5 years: _____

_____ _____

_____ _____

_____ _____

List of Health Problems: _____

_____

_____

_____

_____

List of Medications: _____

_____

_____

_____

_____

FOR OFFICE USE ONLY **Approved for:** _____

Manuli Internal Medicine

104 Mill End Court
Elizabeth City, NC 27909
P: (252)338-5183 | F: (252)338-5669

Patient Information:

Patient Name (Legal): _____ Address: _____

Date of Birth: _____ City: _____

Gender: _____ Ethnicity:_____

Social Security #: _____ State: _____ Zip code: _____

Home Phone #: _____ Email: _____

Work Phone #: _____ Preferred Pharmacy: _____

Cell Phone #: _____ Mail Order Pharmacy: _____

Insurance Information:

Policy Holder's Name: _____ Date of Birth: _____ SSN #: _____

Primary Insurance: _____ Policy #: _____ Group #: _____

Secondary Insurance: _____ Policy #: _____ Group #: _____

Insurance Authorization Agreement:

I hereby authorize Manuli Internal Medicine to furnish any information needed by any insurance carrier(s) to process any claim(s) for services rendered. I authorize payment of medical benefits to Manuli Internal Medicine for services rendered to the above-named patient by Manuli Internal Medicine and/or physician(s) within the practice. I assign any benefits payable by the insurance carrier(s) for those services rendered to Manuli Internal Medicine. ***I agree to be responsible for any amount not covered by insurance or for the full amount if the patient isn't covered by an active insurance policy.***

Patient Name (Print): _____ Date: _____

Patient Signature: _____ Date: _____

Emergency Contact Information:

Name: _____ Home Phone #: _____

Relationship to Patient: _____ Cell Phone #: _____

Name: _____ Home Phone #: _____

Relationship to Patient: _____ Cell Phone #: _____

AUTHORIZATION TO LEAVE MESSAGES WITH HOUSEHOLD MEMBERS AND/OR ON AN ANSWERING MACHINE OR VOICEMAIL

Occasionally it is necessary for the staff of Manuli Internal Medicine to leave messages for patients. The purpose of these messages is to remind patients they have an appointment, to notify the patient that the medical staff would like to discuss test results or appointments with other medical facilities, and/or to ask the patient to call regarding and issue or concern. At no time will a staff member of Manuli Internal Medicine discuss your medical condition to others without your consent. The purpose of this consent is to leave a message with members of your household or on your answering machine.

You have the right to revoke this consent at any time in the future.

I authorize/allow Manuli Internal Medicine to leave messages with members of my household and/or on my answering machine/voicemail:

Patient Name (Print): _____ **Date of Birth:** _____

Patient Signature: _____ **Date:** _____

NO SHOW POLICY:

We schedule our appointments so that each patient receives the right amount of time to be seen by our physicians and staff. That's why it is very important that you keep your scheduled appointment with us and arrive on time.

As a courtesy and to help patients remember their scheduled appointments, Manuli Internal Medicine provided appointment cards upon completion of your visit, we send text message and email reminders immediately following you scheduling an appointment with our office. We also send reminders 1 week and 1 day prior to your appointment.

If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to schedule with the physician, please give us at least **24 hours' notice**. If you do not cancel or reschedule your appointment with at least 24 hours' notice, there will be a $25.00 "no-show" service charge applied to your account. This "no-show charge" is not reimbursable by your insurance company. You will be billed directly for it.

I understand the "no-show" policy of Manuli Internal Medicine. I understand that I must call the office at (252)338-5183 to cancel or reschedule any appointment at least 24 hours in advance in order to avoid a potential no-show charge.

Patient Name (Print): _____ Date: _____

Patient Signature: _____

PATIENT AUTHORIZATION FORM

Many of our patients allow family members such as their spouse, parents, and/or family members to call and request medical or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical and/or billing information released to family members you must sign this form. **Signing this form will only give consent to release this information to the family members indicated below**. This consent form will not allow Manuli Internal Medicine to release any other information to these family members.

You have the right to revoke this consent in writing at any time in the future.

I **authorize/allow** Manuli Internal Medicine to release my medical information _____(initial) and/or billing information _____(initial) to the following individual(s):

1. **Name:** _____ **Contact Number:** _____

   Relationship to Patient: _____

2. **Name:** _____ **Contact Number:** _____

   Relationship to Patient: _____

Patient Name (Print): _____ **Date of Birth:** _____

Patient Signature: _____ **Date:**_____

I **decline** to allow Manuli Internal Medicine to release my medical and/or billing information to anyone other than myself without a signed HIPAA consent.

Patient Name (Print): _____ **Date of Birth:** _____

Patient Signature: _____ **Date:**_____

HIPAA NOTICE OF PRIVACY PRACTICE

As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1966 (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or other health care operations (TPO) and for the other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information (PHI): Your protected health information (PHI) may be used and disclosed by our practice, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay for your healthcare bills, to support the operation of the practice and any other use required by law.

Treatment: We will use and disclose your protected health information (PHI) to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information (PHI), as necessary, to a home agency that provides care for you. For example, your protected health information (PHI) may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information (PHI) will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies may require that your relevant protected health information (PHI) be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations: We may use or disclose, as needed, your protected health information (PHI) in order to support the business activities of our practice. These activities include but are not limited to, quality assessment activities, employee review activities, accreditation activities and conduction or arranging other business activities. For example, we may disclose your protected health information (PHI) to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility. We may use or disclose your protected health information (PHI), as necessary, to contact you to check status of your equipment.

We may use or disclose your protected health information in the following situations without your authorization: as required by law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, legal proceedings, Law Enforcement Agencies, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation. **Required Uses and Disclosures:** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law.

You may revoke this authorization, at any time in writing, except to the extent that your physician or this organization has taken action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with the respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you many not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding and the protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you many ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare

operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as describes in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you the want the restriction to apply.

Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g, electronically.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Practice Manager of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any questions concerning or objections to this form, please ask to speak with our Office Manager in person or by phone at (252)338-5183.

Associated companies with whom we may do business, such as answering or delivery service are given only enough information to provide the necessary service to you. No medical information is provided.

We welcome your comments: Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.

BY SIGNING BELOW, YOU ACKNOWLEDGE THAT YOU HAVE RECEIVED AND REVIEWED THIS NOTICE OF OUR PRIVACY PRACTICE:

PRINT NAME: _____

SIGNATURE: _____ **DATE:** _____

Release of Medical Records

Manuli Internal Medicine
Steven P. Manuli, MD; Mechell Smith, NP-C; Vilayphonh Eure, PA-C; Thaddeus English, PA-C
104 Mill End Court
Elizabeth City, North Carolina 27909
P: (252)338-5183 | F: (252)338-5669

Information to be Released

The information covered by this authorization includes: _____

Persons Authorized to Release Information

Information listed above will be released by:

1. **Name of Medical Facility:** _____ **Phone #:** _____

Address of Facility (City/State): _____ **Fax #:** _____

2. **Name of Medical Facility:** _____ **Phone #:** _____

Address of Facility (City/State): _____ **Fax #:** _____

Persons to whom information will be received

Information listed above may be released to:

Name of Medical Facility: _____ **Phone #:** _____

Address of Facility (City/State): _____ **Fax #:** _____

Expiration Date of Authorization

*This authorization is effective **6 months** from the date signed unless revoked or terminated by the patient.*

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Manuli Internal Medicine. You should contact the Title of Privacy/Compliance Office to terminate this authorization.

Potential for Re-Disclosure

Information that is disclosed under the authorization may be disclosed again by the person or organization to which it is sent. The privacy if this information may be protected under the federal privacy regulations.

(Name of Patient) **(Date of Birth)**

(Patient Signature) **(Today's Date)**