Campbell University Health Center, LLC
129 T.T. Lanier St. / PO Box 565 Buies Creek, NC 27506
(P) 910-893-1560 (F) 910-814-5727

Patient Registration

Patient's Name _____ **DOB**____-___-_____**Sex: M / F**
(First) (MI) (Last)

Mailing Address:_____

City, State, Zip Code: _____

Home Phone: (____)_____ **Work Phone: (____)**_____ **Cell Phone: (____)**_____

Email address: _____

Race: [ ] American Indian [ ] Asian [ ] African American [ ]Caucasian [ ] Native Hawaiian or Pacific Islander
[ ] Other [ ] Patient Declined

Ethnicity: [ ] Non-Hispanic [ ] Hispanic [ ] Patient Declined

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated

Emergency Contact Information:_____**Relationship**_____

Address:_____**Phone:** _____

INSURANCE INFORMATION: We cannot file your insurance without complete information and a copy of your insurance cards. Please bring your insurance cards with you to the front desk when you have completed this form.

PRIMARY INSURANCE COVERAGE:

Insurance Company: _____

Address: _____

Subscriber ID #:_____**Group #:** _____

Patient Relationship to Policy Holder: _____

Policy Holder's Information: Name:_____**DOB:** _____

Employer: _____

SECONDARY INSURANCE COVERAGE:

Insurance **Company:** _____

_____ **Address:** _____

Subscriber ID #:_____**Group** **#:** _____

Patient Relationship to Policy Holder: _____

Policy Holder's Information: Name: _____ **DOB:** _____

Employer: _____

OTHER INSURANCE: _____

_____

_____

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Medical History

Patient's Name _ **DOB**____-___-____.

Past Medical History (check all that apply and list dates and type if applicable)

☐ Heart Attack ☐ Heart Disease/Angina ☐ Sleep Apnea ☐ Arthritis ☐ Stroke
☐ High Cholesterol ☐ High Blood Pressure ☐ Low Blood Pressure ☐ Thyroid ☐ Anxiety
☐ Depression ☐ Indigestion/Reflux ☐ Diabetes/Type____ ☐ Colitis ☐ ADD/ADHD

☐ Pneumonia ☐ Asthma ☐ Seasonal Allergies ☐ COPD/Emphysema
☐ Polycystic Ovarian Syndrome ☐ Cancer/ Type: _____
☐ Pneumonia ☐ Asthma ☐ Seasonal Allergies ☐ COPD/Emphysema
☐ Osteoporosis ☐ Kidney Disease – Stage_____

Please list any current or past medical condition not listed above: _____

_____

_____

Past Surgical History: (Please include dates and type of surgery)

_____

_____

_____

Health Maintenance (Please list the date of your last exam for each that applies)

Annual Eye Exam:	Breast/Pelvic Exam:
General Physical:	Mammogram:
Colonoscopy:	Pap Smear:
Diabetic Foot Exam:	Abnormal Pap:
Bone Density:	Follow up for Abnormal Pap:
Prostate Exam:	PSA:

Gynecologic History:

Age Periods started:_____Ended:_____Periods are: Regular / Irregular Heavy/ Normal / Light

# of Pregnancies:_____# of Children: _____ Age at first pregnancy:_____Age at last pregnancy: _____

If you have had any diagnostic imaging studies completed recently, please fill out a Medical Record Release form to obtain those reports and images for your provider to review.

(Office Use Only) **Please scan to Patient Registration** **Revised:October 2023**

Name: _____ **DOB:** _____

Allergies: (List any type of reaction)

Medication: _____

_____

Food/ Latex etc: _____

_____

Family History: (Please check all that apply and list your relationship. Example: Mother, Father, Sibling, Maternal or Paternal Grandparent) You may use the back side of this page if necessary.

___Obesity _____ ___Hypertension _____

___Diabetes _____ ___Heart Disease _____

___Stroke _____ ___Kidney Disease _____

___Osteoporosis _____ ___Cancer _____

Social History:

Tobacco Use: (Circle all that apply) **Never, Cigarettes, E-Cigarettes, Cigars, Chewing/Snuff, Gums, Patches or Dissolvable**

If Current User – Amount/Frequency: _____

If Former user – Date Quit: _____

Alcohol Consumption: Never_____Rarely_____Occasional_____Regularly_____Frequency & Type _____

Recreational Drug Use: Never_____Rarely_____Occasional_____Regularly_____

If Current User – Amount/Frequency: _____

If Former user – Date Quit: _____

Do you exercise regularly? _____ How often?_____How long? _____

What type of exercise? _____

Are you employed? _____ Full Time or Part Time? _____

What type of work do you do? _____

Religious Preference: _____

Do you have any hearing impairment, dyslexia, legally blind, ADHD,other?_____

☐

Medications

**Please list all current medications including prescription, herbs, supplements, vitamins & over the counter medications with dosage and how often you take the medication

Medication Name	How I Take It (Dosage & Time of Day)	Reason for Taking This Medication

Review of Systems
(For Physician Use)

(Check all that apply)

- ☐ Fatigue/Tiredness
- ☐ Recent Wt Loss Over 10 lbs
- ☐ Recent Wt Gain over 10 lbs
- ☐ Acne
- ☐ Skin Rash
- ☐ Cough
- ☐ Snoring
- ☐ Shortness of Breath
- ☐ Chest Pain
- ☐ Difficulty Breathing When Flat
- ☐ Fainting/ Blacking Out
- ☐ Palpitations
- ☐ Irregular Heart Beat
- ☐ Swelling Ankles/Extremities
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in Stool
- ☐ Dysphasia/Difficulty Swallowing
- ☐ Food Intolerance
- ☐ Nausea/Vomiting
- ☐ Heartburn/Reflux
- ☐ Gas & Bloating
- ☐ Increased Appetite
- ☐ Decreased Appetite
- ☐ Frequent Urination
- ☐ Slow Urine Flow
- ☐ Night time Urination
- ☐ Loss of Urine Control
- ☐ Back Pain (Upper)
- ☐ Back Pain (Lower)
- ☐ Joint Pain
- ☐ Muscle Aches/Pain
- ☐ Dizziness
- ☐ Headaches
- ☐ Seizures
- ☐ Weakness/Low Energy

(Men)

- ☐ Difficulty with Erections
- ☐ Loss of interest in sex
- ☐ Low testosterone
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Memory Loss
- ☐ Inability to Concentrate
- ☐ Mood Changes
- ☐ Nervousness
- ☐ Loss of Interest
- ☐ Cold Intolerance
- ☐ Excessive Sweating
- ☐ Hair Changes
- ☐ Heat Intolerance
- ☐ Blood Clots

(Women)

- ☐ Absence of Periods
- ☐ Hot Flashes
- ☐ Loss of interest in sex
- ☐ Heavy periods
- ☐ Light periods
- ☐ Facial Hair
- ☐ Difficulty getting pregnant

Other:_____

_____

_____

Patient Authorization Form

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures, and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family member you must sign this form. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. I request that the following communications from this practice be delivered to me/family members by the electronic means provided. I understand that this form of communication may not be secure, creating a risk of improper disclosure to unauthorized individuals. I am willing to accept the risk and will not hold the practice responsible should such an incident occur.

Patient name: _____ DOB:_____

Patient Signature: _____

I authorize Campbell University Health Center to release my records and any information requested to the following individuals.

1. **_____Relation to Patient_____**
2. **_____Relation to Patient_____**
3. **_____Relation to Patient _____**
4. **_____Relation to Patient _____**

If Campbell University Health Center's message contains Protected Health Information (PHI) such as your results lab or imaging, appointment reminders, clinical results, medical, or financial and your greeting identifies you with your name, we can leave a message.

May we contact you by: Phone: _____ Voicemail _____ Email: _____
(Check all that apply)

Patient Signature: _____

Campbell University Health Center, LLC
129 T.T. Lanier St. Buies Creek, NC 27506
(P) 910-893-1560 (F) 910-814-5727

Appointment Cancellation / No Show Policy

Dear Patient,

We strive to provide excellent medical care to you, your family and all of our patients. In order to do so, effectively and efficiently, we have developed an appointment system that sets aside ample time for each patient.

Due to the volume of patients seen daily in our office, “No Shows” and “Last Minute Cancellations” inconvenience those individuals who need access to medical care in a timely manner. In an effort to reduce the number of such occurrences, we have implemented a Medical Appointment Cancellation Policy and it is effective starting immediately.

Our policy is as follows:

1. We request you give our office a 24-Hour notice in the event you need to reschedule your appointment.
2. If you are late for an appointment (meaning more than 15 minutes), depending on the providers schedule and other obligations, we may need to reschedule your appointment for another date and time.
3. Our office strives to make reminder calls for appointments and any changes to your appointment can be made at that time. **However, it is ultimately the patient’s responsibility to remember their scheduled appointments.
4. If you miss an appointment and do not contact us with at least a 24-Hour prior notice, we will consider this a missed appointment and a **$25.00 No-Show fee** will be assessed to you. This applies to late cancellations and “no-shows.”

The $25.00 fee will be billed to you directly and is not covered by your insurance. This balance must be paid prior to your next appointment. If you do not have a scheduled appointment, the balance is expected in a timely fashion and if not, may be subject to collections in accordance with North Carolina and federal laws..

We thank you for trusting Campbell University Health Center with your medical care.

I have read and understand the Medical Appointment Cancellation Policy and agree to the terms of this policy.

Patient Name: _____

Signature: _____

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SIGNATURES OF PATIENT OR AUTHORIZED PERSON

Consent to Treat

I _____ (patient name) give permission for **Campbell University Health Center** to give me medical treatment.

I understand:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my clinician.

RELEASE OF MEDICAL INFORMATION NECESSARY TO REPORT A CLAIM

I HEREBY AUTHORIZE RELEASE OF MEDICAL INFORMATION NECESSARY TO REPORT A CLAIM TO MY INSURANCE PLAN(S). A COPY OF THIS SIGNATURE IS AS VALID AS THE ORIGINAL.

SIGNATURE_____**DATE** _____

I. ASSIGNMENT OF PAYMENT TO THE TREATING PHYSICIAN AND ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

THE SIGNATURE OF THE INSURED OR AN AUTHORIZED PERSON TO ASSIGN BENEFITS OTHERWISE PAYABLE TO THE INSURED TO THE PHYSICIAN INDICATED ON THE CLAIM. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR BENEFITS NOT COVERED BY MY INSURANCE PLAN. A COPY OF THIS SIGNATURE IS AS VALID AS THE ORIGINAL.

SIGNATURE_____**DATE** _____

II. FOR MEDICARE PATIENTS ONLY

I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. I HEREBY AUTHORIZE MEDICARE TO FURNISH TO CAMPBELL UNIVERSITY HEALTH CENTER ANY INFORMATION REGARDING MY MEDICARE CLAIMS UNDER TITLE XVIII IF THE SOCIAL SECURITY ACTS.

SIGNATURE_____**DATE**
_____

WITNESS _____

Campbell University Health Center, LLC
129 T.T. Lanier St / PO Box 565 Buies Creek, NC 27506
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Non-Discrimination and Access to Healthcare

Campbell University Health Center does not discriminate against any person on the basis of race, color, national origin, religion, disability, sex, veteran's status, sexual orientation, gender identity or age with regard to admission, treatment or participation in its programs, services and activities, or in employment. Free foreign language interpreters are available for individuals who are limited English proficient through Cyracom Language Line. Free sign language and oral interpreters, TTY's and other services are available to deaf and hard-of-hearing persons. TTY: 800-233-7082 Voice: 800-999-5737 Video Phone: 919-890-0858 These services are open to Deaf, Hard of Hearing and Deaf-Blind individuals. Family members, professionals, agencies and individuals seeking information or assistance also have access to these services. There is no charge for these services. If you need these services, contact the Campbell University Health Center at 910-893-1560.

Campbell University Health Center, LLC
129 T.T. Lanier St. / PO Box 565 Buies Creek, NC 27506
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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
THE EFFECTIVE DATE OF THIS NOTICE IS: May 23, 2018.

CAMPBELL UNIVERSITY HEALTH CENTER, LLC ("Campbell University Health Center") is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about the privacy practices at CAMPBELL UNIVERSITY HEALTH CENTER please contact:

Campbell University Health Center, LLC
129 T.T. Lanier St
PO Box 565
Buies Creek, NC 27506
(910)893-1560

I. How CAMPBELL UNIVERSITY HEALTH CENTER May Use or Disclose Your Health Information

CAMPBELL UNIVERSITY HEALTH CENTER collects health information from you and stores it on a computer. This is your medical record. The medical record is the property of CAMPBELL UNIVERSITY HEALTH CENTER, but the information in the medical record belongs to you. CAMPBELL UNIVERSITY HEALTH CENTER protects the privacy of your health information. The law permits CAMPBELL UNIVERSITY HEALTH CENTER to use or disclose your health information for the following purposes:

1. *Treatment* Treatment activities include a)the provision, coordination, or management of health care and related services by health care providers; b)consultation between health care providers relating to a patient; or c) the referral of a patient for health care from one health care provider to another d.) talk with Pharmacy and Pharmacy Staff regarding treatments and health care.
2. *Payment* Payment activities include: a)billing and collection activities and related data processing; b)actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; c)medical necessity, and appropriateness of care reviews, utilization of review activities; and d)disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.
3. *Regular Health Care Operations* Health care operations include a) development of clinical guidelines; b) contacting patients with information about treatment alternatives or communications in connection with case management or care coordination; c) reviewing qualifications of and training health care professionals; d) underwriting and premium rating; e) medical review, legal services, and auditing functions; and f) general administrative activities such as customer service and data analysis.
4. *Waiting Room* We may need to call you by name when you are in the waiting room.
5. *Notification and communication with family* We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are able and available to agree or object, our health professionals will use their best judgment in communication with your family and others. In the event

of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts.

6. *Required by law* As required by law, we may use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
7. *Public health* As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or other abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medication; and reporting disease or infection exposure.
8. *Health oversight activities* We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings.
9. *Judicial and administrative proceedings* We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
10. *Law enforcement* We may disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.
11. *Deceased person information* We may disclose your health information to coroners, medical examiners and funeral directors.
12. *Organ donation* We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
13. *Research* We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board or Campbell University Health Center's privacy board.
14. *Public Safety* We may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
15. *Worker's compensation* We may disclose your health information as necessary to comply with worker's compensation laws.
16. *Breach notification* In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

II. When CAMPBELL UNIVERSITY HEALTH CENTER May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, CAMPBELL UNIVERSITY HEALTH CENTER will not use or disclose your health information without your written authorization. If you do authorize CAMPBELL UNIVERSITY HEALTH CENTER to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time to the extent CAMPBELL UNIVERSITY HEALTH CENTER has not relied upon it.

III. Your Health Information Rights

You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

1. You have the right to receive your health information through a reasonable alternative means or at an alternative location.
2. You have the right to inspect and copy your health information with limited exceptions. We may charge a reasonable fee for copies. We may require inspection or copy requests to be in writing. We may deny your request under limited circumstances and you may have a right to appeal our decision.
3. You have a right to request that CAMPBELL UNIVERSITY HEALTH CENTER amend your health information that is incorrect or incomplete. CAMPBELL UNIVERSITY HEALTH CENTER is not required to change your health information and will provide you with information about CAMPBELL UNIVERSITY HEALTH CENTER'S denial and how you can disagree with the denial.
4. You have a right to receive an accounting of disclosures of your health information made by CAMPBELL UNIVERSITY HEALTH CENTER except that CAMPBELL UNIVERSITY HEALTH CENTER does not have to account for the disclosures described in parts 1 (treatment), 2 (payment), and 3 (health care operations), of section I of this Notice of Privacy Practices.
5. You have a right to a paper copy of this Notice of Privacy Practices.
   If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact

   Campbell University Health Center
   PO Box 565
   Buies Creek, NC 27506 (910) 893-1560

IV. Changes to this Notice of Privacy Practices

CAMPBELL UNIVERSITY HEALTH CENTER reserves the right to amend this Notice of Privacy Practices at any time in the future, and to make the new provisions effective for all information that it maintains, including information that was created or received prior to the date of such amendment. Until such amendment is made, CAMPBELL UNIVERSITY HEALTH CENTER is required by law to comply with this Notice

I. Complaints

Complaints about this ***Notice of Privacy Practices*** or how CAMPBELL UNIVERSITY HEALTH CENTER handles your health information should be directed to:

Campbell University Health Center PO Box 565
Buies Creek, NC 27506 (910) 893-1560

Campbell University Health Center, LLC
129 T.T. Lanier St. / PO Box 565 Buies Creek, NC 27506
(P) 910-893-1560 (F) 910-814-5727

Acknowledgement of Receipt of Notice

I hereby acknowledge that I received a copy of this medical practice's ***Notice of Privacy Practices.***

Signed: _____ Date: _____

Print Name:_____Telephone: _____

If not signed by the patient, please indicate relationship to patient: _____

Name of Patient: _____

Date of Birth: _____

Signed form received by: _____

Acknowledgement refused: Effort to obtain by: _____