East Cary Family Physicians

103 Parkway Office Ste. 104
Carv. NC 27518
Office (919) 200-6587
Fax (855) 653-2362
Gunjan Nigam, MD

New Patient Registration Form - page 1

PATIENT INFORMATION

Patient's first name:	Patient's middle name:	Patient's last name:

Patient date of birth: / /	Patient sex: ☐ M ☐ F	Marital status: ☐ single ☐ married ☐ divorced ☐ widowed ☐ other	Patient's social security number: — —

Patient's mailing address:	City:	State:	ZIP code:

Home phone number: ( ) —	Cell phone number: ( ) —	Work phone number: ( ) —

Email address:

Employment Status: ☐ full time ☐ part time ☐ self employed ☐ not employed ☐ retired	Student Status: ☐ not a student ☐ full time student ☐ part time student

RESPONSIBLE PARTY (GUARANTOR)

If the guarantor is the same as the patient, check here and proceed to the next section: ☐ guarantor is same as patient

A guarantor is the person responsible for the patient's bill. If the patient is a minor (under the age of 18) or has a legal guardian, then the parent or legal guardian bringing the patient to the visit and signing the Financial Responsibility Statement is usually the guarantor for the patient.

Guarantor's first name:	Guarantor's middle name:	Guarantor's last name:

Guarantor's date of birth: / /	Guarantor sex: ☐ M ☐ F	Marital status: ☐ single ☐ married ☐ divorced ☐ widowed ☐ other	Guarantor's social security number: — —

Guarantor's mailing address: ☐ same as pt.	City:	State:	ZIP code:

Guarantor's home phone number: ( ) —	Guarantor's cell phone number: ( ) —	Relationship to patient:

OTHER CONTACT INFORMATION

Emergency contact name:	Relationship to patient:	Primary phone number: ( ) —	
Emergency contact mailing address: ☐ same as pt.	City:	State:	ZIP code:
Spouse / Parent / Legal guardian name:	Relationship to patient:	Primary phone number: ( ) —	
Spouse / Parent / Guardian mailing address: ☐ same as pt.	City:	State:	ZIP code:

Please proceed to the reverse side of this form to complete.

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New Patient Registration Form – page 2

PRIMARY INSURANCE INFORMATION		
Name of primary insurance company:	Subscriber ID number:	Effective/start date:
If the primary insurance subscriber is different from the patient, please complete the following section.		
Subscriber's first name:	Subscriber's middle name:	Subscriber's last name:
Subscriber's date of birth: / /	Subscriber sex: ☐ M ☐ F	Patient's relationship to subscriber of primary insurance: ☐ Spouse ☐ Child ☐ Other - please specify:

SECONDARY INSURANCE INFORMATION		
Name of secondary insurance company:	Subscriber ID number:	Effective/start date:
If the secondary insurance subscriber is different from the patient, please complete the following section.		
Subscriber's first name:	Subscriber's middle name:	Subscriber's last name:
Subscriber's date of birth: / /	Subscriber sex: ☐ M ☐ F	Patient's relationship to subscriber of secondary insurance: ☐ Spouse ☐ Child ☐ Other - please specify:

OTHER DEMOGRAPHICS	
Language preferred by patient for office visits: ☐ English ☐ Spanish ☐ Other – please specify:	
Which category or categories best describe the race of the patient? (*Mark all that apply.*) ☐ American Indian or Alaska Native ☐ Black or African American ☐ Asian ☐ White ☐ Native Hawaiian or Pacific Islander ☐ Other Race ☐ Declined to Answer	Please specify ethnicity of patient: (*Check one.*) ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to Answer

PHARMACY INFORMATION		
Local pharmacy name:	Local pharmacy location:	Local pharmacy phone number: ( ) —
Mail order pharmacy name:	Mail order pharmacy location:	Mail order pharmacy phone number: ( ) —

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. I will notify East Cary Family Physicians if any of this information changes.

Signature of Patient or Authorized Representative

Date Signed

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Gunjan Nigam, MD

Patient Agreement - page 1

Calling our Office

Non-emergency and non-urgent telephone messages for providers may be left by calling 919-460-2015. Outline the nature of your concern so the medical assistant can convey your question to your provider. Also leave a contact telephone number. Calls received will be returned by our medical assistants once reviewed by the physician.

Please note that if your question or concern involves symptoms that need to be evaluated, you should schedule an appointment. Your physician cannot diagnose over the phone. Also, if you feel that your question should be addressed that day, it is best to schedule a same-day appointment as scheduled patients always have priority during the clinic day.

Emergencies/Urgent Needs/After-Hour Calls

If you have a life-threatening emergency, please call 911 or go to the nearest emergency room. For urgent needs during office hours, call 919-460-2015 to speak to a medical assistant.

For urgent (but not life-threatening) needs when the office is closed, call the on-call line at 919-460-2018 to leave a message for the on-call provider. The covering provider will get back to you as quickly as possible. If you have not heard back within 20 minutes, please repeat the process. Be sure to leave your name, your date of birth, a number where you can be reached, the nature of the problem, and your provider's name. Please do not leave messages regarding non-urgent matters or prescription refills.

Hospitalizations

If you are admitted to the hospital, please notify our clinic as soon as possible so what we can coordinate care with the Hospitalist in charge of your inpatient hospital care. When you are discharged from the hospital, please contact us as soon as possible so that we can arrange for a hospital follow-up visit to review the recent events, review any medication changes made, and arrange for further treatment or referrals needed.

Late Arrivals/Cancellations/Missed Appointments

Please be on time for your visit as late arrivals can delay other patient appointments. While our physicians are sometimes delayed with a given patient, they do their best to stay on schedule. If you arrive more than 15 minutes late for your appointment, you may need to be rescheduled depending on the day's schedule and the nature of your visit. If you need to be rescheduled due to a late arrival, you may be subject to a missed appointment fee.

Please let the office know at least 24 hours in advance if you are unable to keep an appointment. This allows us to have more room on the schedule for same day appointments for other patients with urgent needs.

Prescription Refills

For refills of your routine medication between appointments, please directly contact your pharmacy to request the refill. If there are no remaining refills on the prescription, your pharmacy will issue an electronic refill request to our office for approval from your physician. Please allow 3 business days for this process to be completed for all regular medications. An appointment will be required for any new prescription and usually for refills on controlled substances. For emergency refills, call your pharmacy which can usually provide a limited emergency supply.

Form Completion

We are happy to complete forms as required by your employer, school, or camp. Please complete your portion of any needed forms prior to submitting them to us. We will attempt to complete the form as soon as feasible; most forms are completed within 7 days, but more complex forms may take longer, so please plan accordingly. Some forms may incur a processing fee or may require an appointment for completion. Due to privacy rules, we do not email or fax forms to employers or schools. You will need to pick them up in our office or arrange to have them mailed to you.

I have read, understood, and agree to all of the terms and conditions contained herein. _____ (Initial)

Please proceed to the next page of this form to complete.

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Gunjan Nigam, MD

Patient Agreement - page 2

Primary Care Agreement

We are pleased that you have chosen Dr. Nigam as your Primary Care Physician (PCP) at East Cary Family Physicians. It is our goal to deliver the best health care possible, and we are dedicated to providing comprehensive primary care for women, men, and children of all ages, including preventive care, acute problem management, and chronic disease care management. We look forward to partnering with you on your health needs for years to come.

Preventive Care Visits

A Preventive Care Visit includes a routine physical exam, health screenings, immunizations, and other preventive services. Many health plans do not require a copayment, deductible, or coinsurance for visits during which *only* preventive services are provided.

Note that at Preventive Care Visits, if you have symptoms that need to be evaluated or chronic diseases/conditions that require significant evaluation and management, the visit is considered a diagnostic visit, and you will most likely be required by your insurance company to pay a copayment, deductible, or coinsurance.

We sometimes will combine a Preventive Care Visit and diagnostic visit at the same visit, if time permits, so that you do not have to come back for a second separate visit in order to have the problems addressed. In these cases, your insurance decides if there are any required copayments, deductibles, or coinsurances applicable to that visit, based on federal laws and your contract with your insurance company.

Chronic Care Management Agreement

An important part of providing primary care for you is chronic care management. Our goal is to make sure you get the best care possible from everyone that is involved with your care.

As part of chronic care management, we can help coordinate your visits with other doctors, facilities, lab, radiology, or other testing; we can talk to you on the phone about your symptoms, with access to your care team 24 hours-a-day, 7 days-a-week, including telephone access and other non-face-to-face means of communication; we can help you with the management of your medications; and we will provide you with a comprehensive care plan.

Your designated physician in charge of your care will be noted in your medical record. Sometimes other physicians or staff from our practice will talk to you or handle issues related to your care, but please know that your assigned physician will supervise all care provided by our staff or other physicians who may be involved in your care.

Some insurances and Medicare allow primary care doctors to bill for chronic care management services during any month in which at least 20 minutes of non-face-to-face care is provided to you for your chronic conditions. Although usual deductibles and coinsurances apply to this service, chronic care management may help avoid the need for more costly face-to-face services in the future by proactively managing patient health, rather than only treating disease and illness.

Only one physician can be designated as your primary care physician and bill for these services in any one calendar month; therefore you must let us know if you decide to designate another physician as your primary care physician.

You must provide your consent to participate in chronic care management services in order for us to bill your insurance or Medicare for these services. You may discontinue this service at any time by notifying us in writing of your intent to end your chronic care management services.

I have read, understood, and agree to all of the terms and conditions contained herein. _____ (Initial)

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Patient Agreement - page 3

Insurance and Payments

- Payment is due in full at the time of service. Methods of payment include cash, check, credit cards, and pre-approved insurance for which we are a contracted provider and are the designated Primary Care Provider (PCP), if applicable. If you are unable to make a payment or establish a payment plan to pay past due balances, you may be asked to reschedule your appointment.
- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate demographic information (such as address, phone number, etc.) and insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible for any services not covered by your insurance.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company; your covered benefits and any exclusions in your insurance policy; and any pre-authorization requirements of your insurance company.
- If we have a contract with your insurance company, we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 30-45 days from the time the claim is submitted to the insurance company. Claims not paid by insurance within 60 days of the initial submission will be assigned to patient responsibility.
- If we do not contract with your insurance company, or if you do not have any health insurance, you will be expected to pay for all fees and charges for services rendered before you leave the office.

Practice Fees

- **Medical records request**: Most requests for medical records will be completed within 7 days of receipt of a valid Release of Information. There is a medical records copy fee (based on number of pages requested, with a $10 minimum for processing) which is due when the request for the records is made.
- **Returned checks**: There is a returned check fee (currently $25) for any checks refused by the bank because of insufficient funds, no valid account at that bank, or any other reason.
- **Missed appointments**: There is a no-show fee (currently $25) for missed appointments unless cancelled or rescheduled at least 24 hours in advance. If you are more than 15 minutes late for an appointment, you may be marked as missing that appointment and may be asked to reschedule. Please notify the clinic as soon as possible if you are going to miss or be late to an appointment. We hope this missed appointment policy will create more availability of same day appointments for our patients by reducing unused appointment slots on the schedule.
- **Unpaid copayments**: There is a late fee (currently $10) added to the visit for copayments not received at the time of service and not paid within 48 hours. Please bring in your copayment for every visit as we are required by your insurance to collect this at the time of service.
- **Unpaid statement balances**: There is a late fee (currently $20) applied to your account for any statement balance that is not paid within 30 days of the statement date, unless a payment plan agreement is signed and in good standing. If you are having difficulties making a payment on a due balance, please contact the office as soon as possible to discuss possible arrangements for a payment plan.
- **Collections**: Any account with an outstanding balance after 90 days of the date of service may be referred to an outside collection agency or attorney for collection, unless a payment plan agreement is signed and in good standing. Accounts referred to an outside collection agency or attorney for collections may be subject to a collection fee (currently 30%) which will be added to the total balance at the time of adjustment. If the account is turned over to a collection agency or attorney for collections, you agree to pay all collection agency fees, court costs, and attorney fees, and you risk being dismissed from our practice.
- **Fee updates**: For an updated list of Practice and Other Fees, please contact the office or visit our website.

I have read, understood, and agree to all of the terms and conditions contained herein. _____ (Initial)

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Patient Agreement - page 4

I do hereby consent to and authorize the performance of all treatments, procedures, and medical services deemed advisable by the physicians and staff of East Cary Family Physicians to me or to the above-named patient of whom I am the parent or legal guardian. I understand that no promises have been made to me about the results of any treatment or services.

I have read the Primary Care and Chronic Care Management Agreement which explain the services offered by this office. I understand and agree that the patient's primary care physician (as documented in the Electronic Health Record) at East Cary Family Physicians will provide these services, including chronic care management services, to the patient. I agree to notify East Cary Family Physicians in writing if I wish to revoke these services or change which physician will provide these services.

I authorize the use of electronic communication of medical information with other treating practitioners and providers when necessary. I also authorize East Cary Family Physicians to view prescription history from external sources when necessary.

I understand that as part of my health care, East Cary Family Physicians originates and maintains paper and/or electronic records which contain Protected Health Information such as descriptions of my health history, symptoms, examination, and test results, diagnoses, treatment, and any plans for future care or treatment. I agree that I have had an opportunity to receive and review the Notice of Privacy Practices of East Cary Family Physicians. I understand that a copy of this notice is also available in the office and on the practice website.

I have read and agree to East Cary Family Physician's Financial Agreement, and I hereby acknowledge direct financial responsibility for all charges and fees for me or for the person whose account I am acting as guarantor. I am responsible for knowing how Medicare, Medicaid, or any health plan I have works, and I am responsible for any non-covered services or fees, supplies, copayments, and deductibles. I understand that it is mandatory to notify the healthcare provider if there is any other party who may be responsible for paying for any services provided.

I authorize the release of any medical or other information necessary to complete and file medical claims to insurance companies, Medicare, or Medicaid on my behalf or on behalf of the above-named patient. I also authorize (assign) any insurance, Medicare, or Medicaid payment of medical benefits to be paid directly to West Cary Family Physicians or its assignees. This acceptance and assignment will be in force for all current and future services by any providers from this office.

My signature on this page indicates acknowledgement of, and consent to, all of the above. I fully understand this agreement, and consent will continue until cancelled by me in writing.

Patient's first name:	Patient's last name:	Patient date of birth: / /

Signature of Patient or Responsible Party

Date Signed

Printed Name of Person Signing This Form

Relation to Patient

East Cary Family Physicians

New Patient Health Questionnaire

PATIENT NAME:	**Date of birth:**

Medical Conditions

Have you been diagnosed with any of the following medical conditions?

☐ Diabetes ☐ High Blood Pressure
☐ Thyroid Condition ☐ Heart Disease
☐ Cancer ☐ Asthma
☐ Allergies ☐ Psychiatric Conditions
☐ HIV ☐ High Cholesterol

Check the box and give the date if you had any of the following:

☐ Flu shot _____ ☐ Pneumonia Shot _____ ☐ Tetanus _____

☐ Colonoscopy_____ ☐ Bone Density_____ ☐ Last physical_____

If you are a female: ☐ Last Pap Smear_____ ☐ Mammogram_____

Please list any other past medical conditions:		

List all medications that you take including prescribed drugs, inhalers, over-the-counter medications, herbal medications, etc.		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

East Cary Family Physicians

New Patient Health Questionnaire

PATIENT NAME:	**Date of birth:**

List all surgeries you have ever had.	
Year	Reason

FAMILY HEALTH HISTORY		
	AGE	SIGNIFICANT HEALTH PROBLEMS
Father		
Mother		
Brother(s)		
Sister(s)		
Other		

SOCIAL HISTORY
Have you ever smoked?
Do you drink alcohol?
Have you ever used illegal drugs?
What is your marital status?
What is your occupation?

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree.

- ☐ Unexplained changes in weight
- ☐ Fatigue
- ☐ Chest Pain
- ☐ Coughing
- ☐ Shortness of breath
- ☐ Blood in stool or dark black stool
- ☐ Getting up at night to urinate frequently
- ☐ Loss of bladder control or leaking urine
- ☐ Recent joint or muscle pain
- ☐ Moles that concern you
- ☐ Swelling or lumps in the breast
- ☐ Passing out or loss of consciousness
- ☐ Poor memory or memory loss
- ☐ Depression
- ☐ Excessive thirst
- ☐ Excessive urination
- ☐ Intolerance of cold
- ☐ Intolerance of heat

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Patient's first name:	Patient's last name:	Patient date of birth: / /

COMMUNICATION PREFERENCES

We may need to communicate test results, prescription information, or appointment reminders to you, or we may need to respond to a message you left for your physician's office. Communication with you may occur through mail, secure email, or telephone, including leaving messages on your answer machine or voicemail. We request that you complete this section identifying the best ways to provide you with your confidential information. Please indicate your preferences in this section.

Primary phone preference for voice calls:	Primary phone preference for text messages:
☐ home ☐ cell ☐ work ☐ declined/do not call	☐ home ☐ cell ☐ work ☐ declined/do not send texts

Automated voice reminders for appointments: ☐ yes ☐ no

Text reminders for appointments: ☐ yes ☐ no

PATIENT PORTAL

Our HIPAA secure patient portal is a user-friendly, password protected web-based communication link between you and East Cary Family Physicians. It gives patients convenient 24-hour access to their personal health information from anywhere with an internet connection, including the ability to view health information and to communicate via secure messages with their physicians and staff. By providing us with your email address, you will receive an email explaining how to set up your access to the patient portal. You will be able to log in to the patient portal from our website at www.eastcaryfamilyphysicians.com

Email address: ☐ no change

PERMISSION TO DISCLOSE INFORMATION TO OTHERS

If you give permission for us to communicate with anyone else, please complete the list below and indicate what information can be discussed. Please note that East Cary Family Physicians reserves the right to communicate Protected Health Information with family or friends when it is deemed necessary and in the best interest of the patient, as described in the Notice of Privacy Practices.

Name and Phone Number	Relationship to Patient	Options (*Check all that apply*)
Name: Phone:		☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information
Name: Phone:		☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information
Name: Phone:		☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. I will notify East Cary Family Physicians if any of this information changes.

Signature of Patient or Responsible Party

Date Signed