WALK IN ONLY

Mt. Olive Family Medicine Center
Caring for Your Whole Family
Completing the Circle of Care

New Patients Requiring Pain Management

Mt. Olive Family Medicine Center, Inc. will **NO LONGER** accept patients who require pain management. MOFMC will not be able to accept you as a new patient if you are currently taking **pain medication** such as Oxycodone, Hydrocodone, Oxycontin, Fentanyl, Morphine, Dilaudid, Butrans, Hydromorphone, Nucynta, Kadea, Norco, Tramadol or any other narcotic medication not listed.

We will not accept you as a new patient to refer you to pain management if you are already taking narcotics.

Exception:

If you are **currently being treated** by a pain management clinic and can provide documentation that you are currently under their care and will remain under their care, then we can treat you for your other medical conditions. These may include diabetes, hypertension, or other medical conditions. If at any time you break your agreement with the pain management clinic, you are subject to be dismissed from our practice as well.

I am not taking any of the above medications and understand that Mt. Olive Family Medicine Center, Inc. will **NOT** prescribe them to me.

Patient Signature_____ **Date**_____

Mt. Olive Family Medicine Center providers believe in vaccinations. Therefore, ALL children in our practice must follow the recommended state guidelines for immunizations in order to become an established patient.

Patient Signature_____ **Date**_____

Mt. Olive Family Medicine Center Credit Policy

Payment is due at the time of service for any amount not usually covered by your insurance plan, **including copayments and deductibles**.

If you are unable to pay in full, other arrangements must be made with this office in advance.

Monthly statements will be sent for any balance on your account for $20.00 or more. Balances for less than $20.00 may be sent quarterly, or collected at the next visit. Payment is due upon receipt of statement. If you are unable to pay in full, arrangements must be made with our Accounts Receivable Manager, Heather Tillman, or our billing department. We encourage patients to contact Heather if they have questions at 919-581-4961.

Past Due Policy

If your account is past due, payment arrangements must be made before your next appointment. We do use a collection attorney to collect our past due accounts.

If no payment is received within 90 days and no arrangements have been made, an attempt will be made to contact you by phone. If that is unsuccessful, and neither payment nor arrangements are made, a dismissal letter will be sent. Accounts not paid in full within 30 days of the dismissal letter will be placed for collection and patients will be considered as dismissed from the practice.

Dismissal Policy

If no payment or arrangements are made within 120 days of services rendered, you may only return as a patient if your bill is paid in full or you have a life-threatening emergency.

Return Check Policy

Return checks are subject to a $25.00 service charge from this office and will be handled the same as above.

Patient Signature_____ **Date**_____

Relationship to Patient _____

***Please continue to next page.*

Completing the Circle of Care

Non-Compliance Dismissal Policy

Mt. Olive Family Medicine considers patient health to be our top priority. Therefore, we must have the cooperation of the patient in order to do so. Patients must agree to be compliant in attending regularly scheduled appointments with their primary care provider and taking medications as prescribed. There may also be times when our providers refer you for services outside of our office. It is the patient's responsibility to attend those appointments as well. Not keeping scheduled appointments or following the provider's medical instructions is considered non-compliance. This may result in Mt. Olive Family Medicine dismissing the patient from the medical practice. If at any time you have questions/concerns about your health care, we strongly encourage you to discuss this with your primary care provider.

Patient/Provider Conduct Policy

Mount Olive Family Medicine strives to treat all patients with the upmost respect while providing quality medical care. In return we expect the same treatment towards all staff members. Certain behaviors towards the staff such as: threats, disrespect, or profanity will **NOT** be tolerated. Situations such as these will be documented and reported to our executive and medical directors. This conduct could be grounds for immediate dismissal from the practice.

Patient/Responsible Party Signature_____ Date_____

***Please continue to next page.*

Mt. Olive Family Medicine New Patient Information (WALK-IN)

*(Failure to fill out application **completely** will delay processing your application.)*

Name *(first, middle, and last)* **:**	
Date of Birth:	**Age:**
Sex: *(please circle)* Male / Female	
Social Security Number:	****Please list SSN.**
Mailing Address:	
City:	
State:	
Zip Code:	
Preferred Phone:	
Cell Phone:	
E-mail:	****** for Patient Portal access
Race:	
Ethnicity: *(please circle)* Hispanic / Non-Hispanic / All Others	
Language: *(please circle)* English/ Spanish / Other:	
Marital Status:	
Pharmacy:	***Location:**
Driver License #:	**Issue State:**

GUARANTOR:

Person Responsible for Account:
Relationship to Patient:
Mailing Address:
Home Phone:
Cell Phone:

EMERGENCY CONTACT:

Emergency Contact's Name:
Relationship to Patient:
Home Phone:
Cell Phone:

What kind of insurance do you have?: Medicare Medicaid Self-Pay Other Health Insurance

(Please circle one **and** list your health insurance on the next page.)

*******Medicaid members:** Please check your Medicaid card to see what facility you are assigned to.

***Please continue to next page.*

PRIMARY INSURANCE INFORMATION: INFORMATION BELOW MUST BE INCLUDED

Insurance Company Name:
Subscriber Name:
Subscriber Date of Birth:
Relationship to Patient:
Policy Number:
Group Number:

SECONDARY INSURANCE INFORMATION: *(if applicable)*

Insurance Company Name:
Subscriber Name:
Subscriber Date of Birth:
Relationship to Patient:
Policy Number:
Group Number:

PATIENT EMPLOYMENT INFORMATION: ☐ I am unemployed.

Employed By:		
Employer's Address:		
City:	**State:**	**Zip Code:**
Business Phone:		
Occupation:		

I affirm that the information I have given is correct to the best of my knowledge. I assign Mt. Olive Family Medicine Center all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize MOFMC to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions whether manual or electronic. I acknowledge receipt of the notice of privacy practices of MOFMC. I understand that the notice of privacy practices contains information on uses and disclosures of any personal health information, and I have been given the opportunity to review the notice. I understand that the terms of the notice may change and that I will be given a revised notice if changes occur. I understand that I may request restrictions on the uses and disclosures of information for the purpose of treatment, payment, or health care operations. I also understand that MOFMC is not required to agree to such requests, but that if it does agree, those restrictions are binding on Mt. Olive Family Medicine Center, Inc.

Patient/Responsible Party Signature_____ Date_____

***Please continue to next page.*

Mt. Olive Family Medicine Center Medical History

*(Failure to fill out application **completely** will delay processing your application.)*

Patient Name:
Date of Birth:

List all current prescriptions, vitamins, supplements, or over the counter medications. Include dosage and how many times taken per day. If you need more room to include additional medications, please attach a list with the information below. **BRING ALL MEDICATIONS WITH YOU TO EACH APPOINTMENT.

Medication:	**Dosage:**	**How often:**
Medication:	**Dosage:**	**How often:**
Medication:	**Dosage:**	**How often:**
Medication:	**Dosage:**	**How often:**
Medication:	**Dosage:**	**How often:**

Are you prescribed any pain medication? *(please circle)* Yes / No
If yes, name of medication:
If yes, who has been prescribing this medication for you?

WOMEN ONLY: Do you suspect you are pregnant? *(please circle)* Yes / No
Are you currently nursing? *(please circle)* Yes / No

MEDICAL PROBLEMS: *Please check all that apply.*

○ Heart Problems	○ Diabetes	○ Mental Illness
○ High Blood Pressure	○ Blood Clots	○ Venereal Disease/STDs
○ Pacemaker	○ Stroke	○ Hepatitis
○ Artificial Heart Valves	○ Radiation Treatment	○ HIV/AIDS
○ ICD Defibrillator	○ Cancer	○ Chemical Dependency

Food Allergies & Reactions:
Drug Allergies & Reactions:
Environmental Allergies:
Do you take allergy injections? *(please circle)* Yes / No

SURGICAL HISTORY

Procedure:	**Year:**	**Location:**
Procedure:	**Year:**	**Location:**
Procedure:	**Year:**	**Location:**
Procedure:	**Year:**	**Location:**
Procedure:	**Year:**	**Location:**
Procedure:	**Year:**	**Location:**

***Please continue to next page.*

Health Habits/Personal History

*(Failure to fill out application **completely** will delay processing your application.)*

Patient Name:
Date of Birth:
Do you have a family history of *(please circle)* : Cancer / Heart Disease / Diabetes
Do you have any children at home? *(please circle)* Yes / No **If yes, how many? _____**
How many adults live in your home? _____
Do you use caffeine? *(please circle)* Yes / No
Have you ever abused prescription medications? *(please circle)* Yes / No / Past
If yes, what medication did you abuse? _____
Is there anything else we should know about your medical history?

Tobacco Use: *(please check)*

- ○ Not applicable – patient is a child
- ○ Current every day smoker How many per day? _____ For how many years _____
- ○ Current some days smoker How many per week? _____ For how many years? _____
- ○ Former smoker How many years did you use tobacco products? _____
- ○ Never smoker
- ○ Only uses smokeless tobacco

Alcohol Use: *(please check)*

- ○ Not applicable – patient is a child
- ○ Never drinks alcohol
- ○ Occasional drinker
- ○ Current everyday drinker How many drinks per day? _____
- ○ Past only

Illegal Drug Use/History: *(please check)*

- ○ Not applicable – patient is a child
- ○ Have never used illegal drugs
- ○ Currently uses illegal drugs What drugs do you use? _____
- ○ In the past only What drugs did you use? _____ How many years? _____

I affirm that the above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance for benefits for which I am entitled. I will not hold my medical provider or any member of his/her staff responsible for errors or omissions that I may have made in the completion of this form. In addition, by signing below, I consent to Mt. Olive Family Medicine Center downloading my E-Med prescription history in order to better assist in my personal care. I also authorize MOFMC to order the performance of blood tests to determine the presence or absence of antibodies of HIV and HBV in my blood if a healthcare provider is directly exposed to my blood or bodily fluids in a manner which may transmit disease.

Patient/Responsible Party Signature_____ Date_____