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**_____

Welcome to Our Practice

We are happy that you have chosen our practice as we will strive to meet all of your medical needs.

Please take the time to answer the questions in this new patient packet carefully and completely and sign your name in all appropriated places. This is the most important thing you can do to help us take care of you. Please complete these forms in blue or black ink, and either mail them back to 201 N. Breazeale Ave Mt. Olive, NC 28365, or drop them off at the front desk.

Following this letter, we have also included information about our practice to help you understand our privacy, medication, and credit policies. If you have any questions about the forms or policies of the office, please feel free to contact us.

If you cannot keep an appointment, please remember to call our office at least 24 hours in advance so that the time can be made available to other patients. Remember to bring all medications, insurance cards, valid photo ID, and copay or deductible payments to each visit.

Thank you for choosing our practice for your care. We look forward to taking care of you and your family.

IF YOUR CHILD IS 18 YEARS OF AGE OR OLDER, THESE FORMS MUST BE SIGNED BY THEM UNLESS THERE IS A VALID MEDICAL REASON PREVENTING IT.

Mt. Olive Family Medicine Center Medication and Refills Policy

WE REQUIRE THAT YOU BRING ALL OF YOUR CURRENT MEDICATION BOTTLES YOU ARE PRESCRIBED BY MOFMC OR ELSEWHERE TO EACH AND EVERY APPOINTMENT. THIS IS FOR YOUR SAFETY.

In order to keep thorough documentation and a consistent plan in place, you need to call your pharmacy and ask them to fax your refill request to our office. This will ensure accuracy of prescripton drug names, current dosing, and timing of refills. This is the fastest way to get your medication. If there is a problem with your refill, call our refill line at **919-658-4954 ext. 1026**.

- Be sure to leave all requested information in your message.
- Please DO NOT call in a refill at MOFMC if you have already requested it from your pharmacy.
- Please DO NOT leave refill requests on any voicemail box other than the one designated at extension 1026.
- Please DO NOT call the nurse's line or your doctor's nurse to request refills. The nurses are very busy all day long and this will slow down their response times and the refill process. If you have a question about a prescription, contact your pharmacist or your nurse.
- You should monitor your supply on hand and always call ahead to allow our office at least 48 hours to process your request. Duplicate calls will slow down our response time.

Medications including antibiotics for acute problems are not to be called in without the patient being seen first. To ensure your safety, quality of care, proper diagnosis, and appropriate antibiotic usage, a provider must evaluate you. We will have a walk-in clinic, with no appointment necessary, to handle these acute situations.

If you are taking any controlled drugs (such as narcotic pain medication), you will be asked to sign a *Controlled Substance Agreement* to ensure proper prescribing and administration of these medications.

- For your safety, only your primary care provider will refill controlled drugs. **This is not something that will be handled in the walk-in clinic.**
- Controlled medications will not be refilled after normal office hours or on Saturdays.
- There are regulations on controlled medications that this office must follow.
- You are responsible for keeping these medications in a safe and secure place at all times.

You need to schedule and keep routine appointments with your primary care provider if you are on any health maintenance medications for conditions such as high blood pressure, diabetes etc. Your provider will make sure that you do not run out of your required medications if they are seeing you on a routine basis. Please do not use the walk-in clinic as a resource to get your maintenance medications refilled.

Thank you for your cooperation and for working in partnership with your provider and your pharmacist to provide medication safely and responsibly. Always inform your provider about any medication allergies, reactions, or sensitivities you may have. Always review literature that is provided for possible side effects and drug interactions you should be alerted to.

Please note that prescriptions are NOT refilled after regular business hours, on weekends, or holidays. Regular business hours at MOFMC are Monday-Friday from 8:00am—5:00pm.

Patient Signature_____ Date_____

Relationship to Patient _____

***Please continue to next page.*

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.*

Mt. Olive Family Medicine New Patient Information

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

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

GUARANTOR:

Person Responsible for Account:
Date of Birth of Responsible Party:
Relationship to Patient:
Mailing Address:
Home Phone:
Cell Phone:

EMERGENCY CONTACT:

Emergency Contact's Name:
Date of Birth of Emergency Contact:
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.

PRIMARY INSURANCE INFORMATION: INFORMATION BELOW MUST BE INCLUDED

☐ I have no health insurance to file at this time.

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 / None
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_____

***Please continue to next page.*

MOUNT OLIVE FAMILY MEDICINE CENTER, INC.

AUTHORIZATION TO RELEASE INFORMATION TO SOMEONE OTHER THAN THE RESPONSIBLE PARTY

On the lines below list the full names of anyone that you authorize MOFMC to recognize as allowed to speak and/or represent on your behalf. MOFMC will not release private medical information OR prescriptions to anyone **including your spouse** without your consent.

*** In the case of a minor under 18 years of age, ensure to list anyone, other than the child's parent(s), who would be authorized to bring them to appointments and/or to contact our office on behalf of the parent(s). This includes grandparents and immediate family members. ***

PATIENT NAME: _____ DOB: _____

☐ I authorize the medical and administrative staff of MOFMC to release information including lab results, appointment information, medical records, insurance, and prescription information to:

NAME	PHONE NUMBER	DATE OF BIRTH	RELATIONSHIP

☐ I **do not** authorize the medical and administrative staff of MOFMC to release any of my medical information to anyone.

❖ **THIS AUTHORIZATION IS PERMANENT UNLESS RETRACTED IN WRITING.**

_____ _____ _____

Signature of Patient/Responsible Party Relationship to Patient Date

_____ _____

Staff Signature Date

In general, the HIPPA privacy rule gives individuals the right to request a restriction on the uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use, disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses of disclosures made pursuant to an authorization requested by the individual. Uses and disclosure for TPO (treatment, payment, and health care operations) may be permitted without prior consent in an emergency.

Mt. Olive Family Medicine Center, Inc.
201 N. Breazeale Avenue, Mt. Olive, NC 28365
Phone # (919) 658-4954 Fax # (919) 658-5754

Patient Authorization for Release of Medical Information

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

Patient Name:
Date of Birth:
Last 4 Digits of Social Security: XXX-XX-__ __ __ __

I hereby authorize the release of my health information

☐ I have **NO** prior medical records. **(Before checking this box, if you have current prescriptions then you have medical records. We need to know who prescribed your medications. This could include hospitals and/or urgent care facilities)**

TO:	**FROM:**
Mt. Olive Family Medicine Center, Inc. 201 N Breazeale Avenue Mt. Olive, NC 28365 Fax #: (919) 658-5754	**Name of Facility:** _____ **Doctor's Name:** _____ **Address:** _____ **Phone #:** _____ **Fax #:** _____

This data shall include:

*The last two years of clinical notes *Most recent labs, x-rays, EKGs, and hospital discharges
*Any information on any major surgery *Medication List
*Vaccination records *Specialist notes
*Problem List * Other: _____

Specific purpose for this request: **new primary care provider**

This consent will be valid for one year. I certify that this authorization is made freely, voluntarily, and without coercion. I understand that the information to be released may include information regarding drug abuse, alcohol abuse, HIV infection, AIDS or AIDS related conditions, psychological, psychiatric, or physical impairments. I understand that the information to be released is protected under state and federal laws and cannot be re-disclosed without my further written consent unless otherwise provided for by state and federal law. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. I have received a copy of this authorization for my records.

Patient Signature_____ Date_____

Relationship to Patient _____

Witness: _____ Date _____

Revocation:

The patient has a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, Mt Olive Family Medicine must receive the revocation in writing. The revocation must include the following:

1. *The patient's name and address*
2. *The effective date of this authorization and the recipients of the protected health information according to this authorization.*
3. *The patient's desire to revoke this authorization.*
4. *The date of the revocation and the patient's signature.*

Mt. Olive Family Medicine will accept written revocations of this authorization in person, by certified mail or by fax. Revocations are not effective until received by Mt. Olive Family Medicine.

Identification of recipient, if in person

___ Valid DL or ID card ___ Agency photo ID must be presented with agency letter ___ Government Agency ID ___Other photo ID
ID information number _____ Verified By: _____ Date: _____

Completing the Circle of Care

Patient Name:
Date of Birth:

Due to the high volume of patients needing to be seen by their primary care provider at Mt. Olive Family Medicine Center and the importance of attending all scheduled visits, our clinic has established the following guidelines regarding canceled, no show or late appointments.

Cancel/No Show Policy

1. Patients/guarantors must notify Mt. Olive Family Medicine Center at 919-658-4954 within 24 hours of their scheduled appointment if they need to cancel an appointment. This allows the clinic to schedule another patient in that time slot.
2. Patients/guarantors who do not call within 24 hours of their scheduled appointment and/or fail to show up for a scheduled appointment will be considered a "no show."
3. **New patients** who "no show" their first scheduled appointment with Mt. Olive Family Medicine Center, will automatically be dismissed from the practice and no future appointments will be scheduled.
4. Patients/guarantors with 3 or more "no show" appointments within a 12 month period will receive a certified letter in the mail, informing of their discharge from the clinic due to excessive "no shows."
5. Patients/guarantors will be charged $25.00 for each no show appointment. You will receive a written notice when a "no show" has occurred. This fee will be due prior to you being seen in our clinic by any provider.
6. It is essential that patients/guarantors make sure contact information, including telephone number and address, stay current with our office. If you have had any change at all please confirm your information is correct on your medical record.

Late Policy

1. Patients who arrive at the clinic more than 15 minutes after their scheduled appointment time will be considered late.
2. Depending on the discretion of the provider, the volume of patients scheduled and the time of arrival, late appointments may be rescheduled for another date/time. If seen, the appointment time may have to be shortened.

Your cooperation is greatly appreciated.

I understand the above statements.

Patient Signature_____ Date_____

Relationship to Patient _____

***Please continue to next page.*

Completing the Circle of Care

Patient Portal

The link to the patient portal can be found on our website www.mofmc.com .

This is not mandatory for our patients, but is an optional service that we offer.

If you are interested in participating in the portal, you must agree to the consent information below and provide the following information to establish your account.

Name: _____

Date of Birth: _____

E-mail Address: _____

Your signature below confirms you have read and fully understand this consent form and wish to participate in our patient portal.

Patient Signature_____ Date_____

Relationship to Patient _____

You will be given a log in and password. You should secure this information so that no unauthorized individuals gain access to your account. The first time you log in you will be prompted to change your password. In the event that you lose or forget your password in the future, we cannot recover the lost password but we can reset the account for you. We ask that you come into our office to have this password reset so that we can confirm we are giving it to the appropriate individual. This may not be convenient but it is for your protection. Upon a successful log in, you will be prompted to also read the "Patient Portal Agreement and Privacy Policy." You must agree in order to proceed into the portal.

THANK YOU FOR PARTICIPATING IN THE PATIENT PORTAL.

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.*

**Please detach and keep this page and the next page for your records.

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

PATIENT COPY

Due to the high volume of patients needing to be seen by their primary care provider at Mt. Olive Family Medicine Center and the importance of attending all scheduled visits, our clinic has established the following guidelines regarding canceled, no show or late appointments.

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Your cooperation is greatly appreciated.

I understand the above statements.

Our Healthcare Team

Mt. Olive Family Medicine Center practices evidence based medicine

•Dr. T. Scott Draughon, Medical Director

Education: East Carolina University Brody School of Medicine. East Carolina Family Medicine. The University of North Carolina at Wilmington.

Board Certifications: Family Medicine

Special Interests: Treating patients across the lifespan

•Dr. Phillip Moye

Education: Saba University School of Medicine. Chief Resident at New Hanover Regional medical Center/UNC Coastal AHEC. North Carolina State University.

Board Certifications: Family Medicine

Special Interests: Pilot Physicals, Acute Care

•Dr. Vincent P Wilson, MD

Education: East Carolina University Brody School of Medicine. Florida Hospital Family Practice. East Carolina University

Board Certifications: Family Medicine

Special Interests: Pediatrics, Sports Medicine, Chronic Conditions

•Dr. Bryon Geer

Education: Des Moines Univeristy Osteopathic Medical Center. York Hospital. University of Virginia

Board Certifications: Emergency Medicine

Special Interests: Acute Care, Trauma

•Misty Rouse, PA-C

Education: Master's Degree in Physician Assistant Studies, Butler University. Bachelor of Science, Campbell University

Board Certifications: Physician Assistant

Special Interests: Acute Conditions, Emergency Care,

•Stacey Hill, PA-C

Education: Master's Degree in Physician Assistant Studies, Chatham University. Bachelor of Science in Biology, Indiana Wesleyan University

Board Certifications: NCCPA, Physician Assistant

Special Interests: Acute Care, Emergency Medicine,

•Meghan S Brown, APRN, FNP-C

Education: Master's Degree in Nursing, The University of North Carolina at Wilmington. Bachelor of Nursing, East Carolina University

Board Certifications: Certified Family Nurse Practitioner

Special Interests: Chronic Illnesses and Comorbidities, Geriatrics, Mental Health

•Carie Brown, FNP-C

Education: Master's Degree in Nursing, The University of North Carolina at Wilmington. Bachelor of Science in Biology, University of Mt. Olive. Associate's in Nursing, Wake Tech Community College. Bachelor of Science in Nursing, Winston Salem State University

Board Certifications: Certified Family Nurse Practitioner

Special Interests: Geriatric Care, Treating patients across the lifespan

•Mark Blizzard, FNP-C

Education: Master's Degree in Family Nurse Practitioner, The University of North Carolina Wilmington. Bachelor of Science in Nursing, University of North Carolina Wilmington. Associate's Degree in Applied Science/Nursing, Wayne Community College.

Board Certifications: Certified Family Nurse Practitioner

Special Interests: Treating patients across the lifespan