Capital Family Physicians, P.A.
2417 Atrium Dr, Ste 201, Raleigh, NC 27607 Ph: (919)-232-0020 Fax: (919) 232-0030

OUR POLICIES AND GUIDELINES

Office Hours: Monday-Thursday 7:00 am - 4:00 pm and Friday 7:00 am – 1:30 pm. Lunch is taken between 12:30 pm – 1:30 pm except Fridays. ***After Hours***: You may call our main number and follow the prompts. The answering service is responsible for paging the physician on call.

Appointments Scheduling: We seek to accommodate the needs of our patients and will schedule your appointment at the most convenient time possible. If you need to be seen the same day, we will work you in with your provider or if possible another available provider.

Insurance and Demographic Information: We must verify your insurance card and demographic information at each visit. This ensures that we process accurate billing for you and your insurance company. If you do not have your insurance card available at the time of the visit you will be considered self-pay and payment is expected at the time of service. **We do not file secondary claims to commercial insurance carriers.**
Federal laws addressing all insurance companies require that we submit your claim to the insurance company accurately and report the exact services performed and the exact reason for performing them. We do Not alter this information (unless there was an error made) so the insurance company can pay the claim.

***Co-pays and Collections*: Your co-pay is due at the time of service**. We are unable to discount or waive this fee due to our contracts with the insurance companies. All deductibles and outstanding balances are also due at the time of your visit. You maybe asked to reschedule your appointment if you are unable to make payment. We accept cash, checks and Visa/Master cards. There is a $25 returned check fee. Accounts past due after 90 days are turned to a collections agency. An additional 35% fee is added to account balances once they are turned to collections.

***No-Show Policy*:** As a courtesy, we attempt to contact every patient to remind them of their appointment; however, it is the responsibility of the patient to arrive for their appointment on time. Cancellations must be received 24 hours in advance, so that we may accommodate patients who need to be seen. Patients who do not contact us prior to their appointment will receive a no-show charge. This fee can range from $25-$75. **If you are late for your appointment you will be asked to reschedule.**

Completion of Forms: Employer, FMLA, insurance forms, or any other paperwork that requires your provider's input, can be very time consuming for both you and your provider. Please be sure to complete all required information with your provider to review the requested information. Fees Start at $25 for completion of forms.

Prescription Refills: Refills must be requested through your pharmacy. They will fax us a request that includes all necessary information. Refills, including sample requests, will be completed within 24-48 business hours. All other clinically, related calls will be handled by your provider or their assistant within 24 business hours. In order to expedite your requests, it is important that you provide complete information when leaving a message.

Test results: Test results may take up to a week. Your provider or their assistant will contact you by telephone or by mail with your test results once they have been received.

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Labcorp Bill: If you have questions about your bill for lab services, we ask that you contact Labcorp directly at 1-800-331-2843.

Referrals: A referral from your provider maybe made to an outside specialist. If your insurance does not require a referral from your primary care provider you may contact that specialist office directly to make an appointment. If your insurance does require authorization from your primary care provider you may be asked to make an appointment with one of our providers before the referral can be issued.

Requests for Medical Records: We will release copies of a patient's medical record with written, signed patient authorization. We outsource record copying to Healthport. They charge the standard legal fees for copies. You will not be charged a fee for records requested by a physician to whom we have referred you.

Worker's Compensation: We do not file worker's compensation claims.

Termination from our Practice: Our office values its patient relationships and wants to protect patients' rights. We will only terminate patient relationships with cause and after careful consideration. Reasons for termination include: repeated not showing for scheduled appointments; not complying with recommended medical care; being hostile or abusive to staff; or not paying bills in a timely manner.

HIPAA: The federal government requires us to share our Privacy Notice, which is posted at the front desk and throughout our practice. Please review the Privacy Notice, which explains policy on sharing patient information for treatment and billing issues.

This is an agreement between Capital Family Physicians and you. By signing this agreement you agree to the policies stated above.

Patient's Name: _____(please print)

Signature: _____

Today's date: _____

Patient Demographics **CHART#**

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Patient Information

☐ Mr. ☐ Mrs. ☐ Ms. Last Name: _____ First Name: _____ Middle Initial: _____
Race:_____Ethnicity_____Preferred Language_____

Social Security Number: ____ - ____ - ____ Martial Status S M D W O Date of Birth: ___/__/__

Home Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number/s:
Home: (_____) _____ - _____ Work: (_____) _____ - _____ Cell: (_____) _____ - _____

Email Address/s:
Home: _____ Work: _____
Employer Name:_____ Address:_____

In Case of Emergency, Notify: Name: _____

Day Time Phone (_____) – _____ - _____ Mothers Maiden Name: _____

Health Insurance

Primary:_____Secondary:_____

Guarantor Name (name on insurance card)

☐ Mr. ☐ Mrs. ☐ Ms. Last Name: _____ First Name: _____ Middle Initial:_____

Social Security Number: _____ - ____ - _____ Date of Birth: _____ / _____ / _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number/s:
Home: (_____) _____ - _____ Work: (_____) _____ - _____ Cell: (_____) _____ - _____

Employer Name & Address: _____

Relationship to Patient: _____

Authorization To Release Medical Information

I authorize that my medical information can be left on my answering machine at home. YES _____ NO _____
I authorize that my medical information can be left on my voice mail at work. YES_____ NO _____

I want to be contacted by: Phone: Home _____ Work _____ Both _____
Voice Mail:_____ Email:_____
Spouse:(Name)_____ Other_____

Signature: _____ Date: _____

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Patient History

Patient's Name _____ Account No. _____

1. Are you allergic to any medications? _____ Which ones and what reaction occurs? _____

_____

2. Do you use tobacco products? _____ What kind? _____ How many? _____
   If you smoked in the past, when did you quit? _____

3. Do you drink alcoholic beverages? _____ Which ones? _____
   How often do you drink them? _____

4. Date of last: Chest X-Ray _____ TB Skin Test _____ Result _____
   EKG _____ Tetanus Shot _____
   Eye Exam _____
   Women Only: Last Menstrual Period _____ Pap Smear _____
   Mammogram _____

5. Past Medical Hospitalizations / Surgery:
   Date **Reason**

_____

_____

_____

6. Family History: Please check if a blood-related family member has had any of the following:

☐ TB	☐ Heart Disease	☐ Bleeding Tendency
☐ Rheumatic Fever	☐ High Blood Pressure	☐ Anemia
☐ Diabetes	☐ Strokes	☐ Arthritis
☐ Thyroid Diseases	☐ Lung Disease	☐ Mental Disease
☐ Cancer	☐ Kidney Disease	☐ Glaucoma

☐ Other _____

7. Other things about your health you wish the doctor to know: _____

_____

8. Do you have any chronic conditions? _____

Please fill in this chart	Age (if living)	Age at Death	State of Health / Details	Cause of Death
Mother				
Father				
Brother (s) How Many?				
Alive _____ Dead _____				
Sister (s) How Many?				
Alive _____ Dead _____				
Children How Many?				
Alive _____ Dead _____				