ACCESS TO THE
HOPE FAMILY CENTER
DR. MYRA DEESE HALL
210 MAGNOLIA SQUARE CT., ABERDEEN, NC 28315
OFFICE: 910-944-0779 FAX: 910-944-2298
WWW.ACCESSTOTHEHOPEFAMILYCENTER.COM

Patient Registration Update: _____

NEW & CURRENT PATIENTS

General Information:

First Name: _____ MI: ____

Last Name: _____

Prefix: _____ Suffix: _____

Address: _____

_____

Zip Code: _____

City: _____

State: _____

Contact:

Cell: _____

Home: _____

Work: _____

Email: _____

Insurance Information:

(This used for referral information only.)

Primary: _____

Secondary: _____

Policy Holder Name: _____

Policy Holder Date of Birth: _____

Policy Holder SS#: _____

Policy Holder Employer: _____

Basic Information:

Gender: ☐ Male ☐ Female

Date of Birth: _____

Employer: _____

Emergency Contact: _____

Relation: _____

Emergency Phone: _____

Responsible Party:

First Name: _____

Last Name: _____

Address: _____

_____

Zip Code: _____

City: _____ State: ____

HIPPA:

I hereby acknowledge that I have a received the Access To The Hope Family Center Notice of Privacy Practices.

Date: _____

Signature: _____

Authorization to Release Information:

I authorize the release of any medical information necessary for a referral to another medical provider. I permit a copy of this authorization to be used in place of the original.

Date: _____ Signature: _____

ACCESS TO THE HOPE FAMILY CENTER

Comprehensive Patient History

Name: _____ Occupation: _____

Date of birth: ____/____/_____ Marital Status: _____ Number of children: _____

Medications *Please include prescriptions, over-the-counter, vitamins, herbs, supplements:*

Name	Dose	Name	Dose

Allergies *to medications, X-ray dyes, latex, foods, other:* ❑ *YES* ❑ *NO* *If YES, please list:*

Medical allergies: _____ Food/other allergies: _____

Past medical history and review of symptoms

Please place a check beside diseases and symptoms you have experienced in the past or are presently experiencing.

- ❑ high blood pressure
- ❑ diabetes
- ❑ heart disease
  - ❑ blocked arteries
  - ❑ skips or rapid rate
  - ❑ murmur / valve problems
  - ❑ heart failure
- ❑ high cholesterol
- ❑ cancer
  type: _____
- ❑ thyroid disease
  type: _____
- ❑ COPD
- ❑ asthma
- ❑ pneumonia
- ❑ nasal allergies
- ❑ neck pain
- ❑ low back pain
- ❑ arthritis
  type: _____
- ❑ gout
- ❑ kidney stones
- ❑ kidney disease
  type: _____
- ❑ BPH
- ❑ urinary tract infection
- ❑ venereal disease
  type: _____
- ❑ hepatitis or jaundice
  type: _____
- ❑ hemorrhoids
- ❑ colitis
  type: _____
- ❑ GERD (heartburn / indigestion)
- ❑ peptic ulcer disease
- ❑ gall bladder disease
- ❑ anemia
- ❑ blood disorder
  type: _____
- ❑ skin diseases
  - ❑ acne
  - ❑ psoriasis
  - ❑ eczema
  - ❑ other: _____
- ❑ varicose veins
- ❑ poor circulation
- ❑ migraine headaches
- ❑ glaucoma
- ❑ macular degeneration
- ❑ fibromyalgia
- ❑ chronic fatigue syndrome
- ❑ depression / suicidal thoughts
- ❑ anxiety / panic
- ❑ alcohol abuse
- ❑ drug abuse
- ❑ head or neck radiation
- ❑ hot flashes / night sweats
- ❑ fever
- ❑ cold or heat intolerance
- ❑ excessive thirst or urination
- ❑ unexplained weight gain / loss
- ❑ swollen glands
- ❑ easy bruising / bleeding
- ❑ fatigue
- ❑ dizziness / light-headedness
- ❑ headaches
- ❑ loss of vision / blurred vision / double vision
- ❑ hearing loss
- ❑ ringing in ears
- ❑ nosebleeds
- ❑ nasal congestion
- ❑ hoarseness / sore throat
- ❑ swallowing problems
- ❑ cough
- ❑ wheezing
- ❑ shortness of breath
- ❑ chest pain / tightness
- ❑ heart skipping / pounding
- ❑ abdominal pain / discomfort
- ❑ nausea / vomiting
- ❑ constipation
- ❑ diarrhea
- ❑ change in bowel habits
- ❑ blood in/on bowel movement
- ❑ frequent urination
- ❑ difficulty urinating
- ❑ burning / pain with urination
- ❑ blood in urine
- ❑ difficulty controlling urine or BM
- ❑ penile discharge
- ❑ difficulty with erections
- ❑ joint pain / swelling
- ❑ foot / ankle swelling
- ❑ rash
- ❑ changing mole
- ❑ skin lump or sore
- ❑ irritability / mood swings
- ❑ weakness
- ❑ numbness / tingling sensation
- ❑ balance problems
- ❑ poor concentration / focus on task
- ❑ memory loss

Gynecologic and obstetric history

Age at onset of periods: _____ Frequency: _____ Length of period: _____

Number of each: Pregnancies: _____ Births: _____ Miscarriages: _____ Therapeutic abortions: _____

Please place a check beside symptoms you have experienced or are presently experiencing. Provide a brief description; include dates.

- ❑ prolonged / abnormal bleeding _____
- ❑ leakage of urine _____
- ❑ pelvic pain _____
- ❑ abnormal discharge _____
- ❑ history of abnormal pap smear _____

Hospitalizations, surgeries, serious injuries *Please provide a brief description; include dates.*

Hospitalizations:	Surgeries:	Injuries:

Continued ➔

Immunization history

Have you had immunization for:

Tetanus ❑ NO ❑ YES When: _____
Pneumonia (Pneumovax) ❑ NO ❑ YES When: _____
Shingles (Zostavax) ❑ NO ❑ YES When: _____
Hepatitis B ❑ NO ❑ YES When: _____
List any other immunizations with dates: _____

Preventive tests

When did you last have the following tests:

Pap smear _____
Mammogram _____
Bone mineral density _____
Breast exam _____
Colonoscopy _____
Cholosterol check _____
Stool check for blood _____
Prostate exam _____

Family History

Has any member of your family (parents, grandparents, or siblings) been diagnosed with the following:

Illness	Family member(s)	Approximate age when diagnosed
Cancer		
type: _____		
type: _____		
type: _____		
Hypertension (high blood pressure)		
Heart disease		
High Cholesterol		
Diabetes		
Stroke		
Mental disease (anxiety, depression)		
Drug addiction		
Alcohol addiction		
Glaucoma		
Bleeding diseases		
Arthritis		
type: _____		
type: _____		
Kidney problems		
Asthma		
Hereditary disease		

Preventive Lifestyle

Do you wear seat belts? ❑ NO ❑ YES If no, why? _____
Do you wear a bike helmet? ❑ NO ❑ YES If no, why? _____
Do you exercise regularly? ❑ NO ❑ YES If yes, what kind, duration, times per week? _____

Do you smoke? ❑ NO ❑ YES If yes, how many packs per day? _____
Do you drink coffee? ❑ NO ❑ YES If yes, how many cups per day? _____
Do you drink tea? ❑ NO ❑ YES If yes, how many cups per day? _____
Do you drink alcoholic beverages? ❑ NO ❑ YES If yes, how many drinks per day? _____ per week? _____
If there is a gun in your house, is it unloaded and out of children's reach? ❑ NO ❑ YES ❑ Does not apply
Do you use drugs (marijuana, cocaine, crack, etc.)? ❑ NO ❑ YES If yes, explain: _____
Have you engaged in activity that has put you at risk for AIDS? ❑ NO ❑ YES If yes, explain: _____
Do you want to be tested for AIDS? ❑ NO ❑ YES
Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? ❑ NO ❑ YES If yes, explain: _____
Are you in a relationship in which you have been physically hurt (slapped, kicked, punched, bruised) by your partner? ❑ NO ❑ YES ❑ Does not apply
Do you ever feel afraid of your partner? ❑ NO ❑ YES ❑ Does not apply
Do you have a "living will"? ❑ NO ❑ YES
Do you have an organ donor card? ❑ NO ❑ YES
Do you use birth control? ❑ NO ❑ YES If yes, which method? _____

New Patient Survey

We would appreciate you taking the time to answer the following questions.

How did you learn about Access To The Hope Family Center?

_____

_____

	Circle Yes or No	
Did anyone refer you to us?	Yes	No
Did you visit our website?	Yes	No
Did you see us on Facebook?	Yes	No
Did you hear about us on the radio?	Yes	No
Did you find us in the phonebook?	Yes	No

Thank you for taking this survey!

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MEMBERSHIP CONTRACT

- **$65 Monthly Membership Fee- Adult**
- **Plus a $25 appointment scheduling fee for each office visit**.

You now have a Medical Home Membership, which will allow you to be scheduled for routine doctor visits for a fee of only $25 per visit. There is no extra charge for most basic lab work for our members. Some non-routine lab work that is sent out is based on actual cost at approximately a 75% discount. **All Annual Healthcare Memberships are non-refundable once any office visits or lab work has been completed**. This represents a private contract between Access To The Hope Family Center and the patient, which is executed after membership payment has been made and initial services rendered. Insurance will not reimburse for the prepaid plans and **this is not a type of insurance**. Access To The Hope Family Center does not file insurance claims or sign insurance contracts. Medicare and Medicaid recipients are not allowed to file claims for Medicare/Medicaid covered services.

Basic lab work that can be performed at no additional charge for members include: Strep Test, CMP, Lipid Panel, TSH, PSA Screening, HgA1C, Urine Dip, CBC, and an Annual Pap Smear.

Members receive an annual EKG at no additional charge. We have arranged for significantly discounted rates at participating facilities for other diagnostic tests such as X-ray, MRI, and Ultrasound testing.

*Services such as sutures or supplies like injections are **not included** or discounted with membership.*

***There is a No-Show fee for missed appointments of $25.00 per episode**.

Please SELECT **One Option** Below:

☐ I, (print name) _____ agree to pay **$685 in full**, for the year starting ____/____/ **20**_____ for this membership and ending on ___/____/**20**_____.

OR

☐ I, (print name) _____ agree to pay **$65 per month (with the first 3 months paid in advance for new patients)** for one year starting ____/____/**20**_____ for this membership and ending on ___/___/**20**_____.

This fee will be drafted from the bank account that you provide on every 1st of the month.

Either prepaid plan entitles me to discounted fees on services at this location only. I will still be responsible for other services not discounted as specifically mentioned above. **At the end of one year, this contract will automatically renew unless you inform us in writing to cancel; however, fees and terms may change annually.**

CONTROLLING LAW: This agreement shall be construed and interpreted in accordance with the laws of the State of North Carolina. As used in this agreement, the singular shall include the plural and the plural shall include the singular and the use of any genders shall be applicable to all genders.

SEVERABILITY/INVALID CLAUSES: The provisions of this agreement are severable and should any provision, clause, sentence, section, or part thereof be found to be invalid, illegal, unconstitutional, inapplicable to any person or circumstance, or otherwise unenforceable, the remainder of the agreement shall not be affected thereby and each term, provision, sentences, clauses, sections or parts of the agreement herein shall be valid and enforceable to the fullest extent permitted by law.

I understand that if I receive services under this agreement and then either fail to make a monthly payment or full annual fee that I will responsible for all charges I have incurred at the normal non-discounted rate.

_____ _____

Signature **Date**

IMPORTANT INFORMATION

- **Bring ALL medications and vitamins to EVERY VISIT!**
- **Make sure ALL of your contact information is updated.**
- **Come in a week BEFORE follow-up appointment for blood work, if blood work is necessary.**
- **Make sure your Credit Card, Debit Card, or Bank account information is current, including the EXPIRATION DATE, for monthly billing to avoid additional service fees. A service fee of $15.00 is charged on all banking returned charges.**
- **All payments must be current to be seen, to receive prescription refills, and/or receive referrals.**
- **Please notify us at least 24 hours before an appointment if you need to cancel or reschedule to avoid a $25.00 service fee.**
- **There is a $25 NO SHOW FEE for each missed appointment.**
- **Important understanding for members paying monthly. If you do not fulfill your terms of payment, you will be held responsible for all unpaid annual charges or you will be charged NON-MEMBER rates. Non-member rates are currently $130.00 per visit plus any additional services.**
- **We require new monthly members to pay the first 3 months in advance ($195.00). After the first 3 months, you will begin paying $65.00 per month on the first of each month.**
- **Failure to make your payment on time may result in being sent to collections and reported to the credit bureau.**
- **Understand that billing may come directly from our office or you may receive bills from our authorized external billing company TWIN OAKS.**
- **All office visits have a $25 scheduling fee.**

We appreciate you taking the time to review the additional information. We find this important to review so we can do everything possible to help keep our prices reasonable for all of our members.

_____ _____

Patient's Signature **Staff member that reviewed this with patient**