Care2u Medical Services PLLC
1230 Hwy 70 E Suite 1 New Bern NC28560
Ph: 252-514-6594 Fax: 888-491-3407
info@care2umedical.com
www.care2umedical.com

Instruction Sheet

PLEASE READ DIRECTIONS CAREFULLY BEFORE FILLING OUT PAPERWORK

To: _____ Date: _____

Thank you for choosing Care2u for your care or for the care of a loved one. In order to provide the best possible care, we need to get as much information as possible prior to the visit. Attached are some forms our office will need you to fill out and/or sign to be given to you clinician on the initial visit.

1. Demographic Intake Form
2. Medical History Form: Please fill this out to the best of your ability and as completely as possible.
3. Consent for Treatment/Privacy Notice/Assignment of Benefits/Payment Agreement/Authorization to Leave Message: ***Please sign in the three places indicated by the*** *X.*
4. Authorization to Release Medical Information: Signing this allows us to get medical records and to send our records to other providers involved in your care. ***(Please fill out only the personal information at the top of page. Do not fill in any requests. The form must be signed by the patient, spouse or the patient's Power of Attorney (POA)***). Please provide a copy of the POA. We will fill out what is needed and send for the information.
5. Statement of Financial Policy: Care2u takes Medicare Assignments and accepts Public Aid. Please read this and sign at the end.
6. An overview on The Health Insurance Portability and Accountability Act of 1996. Care2u prioritizes patient privacy and adheres to all governing regulations in place. Please read and sign to acknowledge our privacy guidelines.

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PATIENT INFORMATION *

Soc Sec Number:_____

Marital Status: Married Widow(er) Divorced Single

Lives Alone: Yes or No

Lives With:_____

Phone:_____

Address:_____

City/State/Zip:_____

E-Mail Address:_____

***RESPONSIBLE PARTY INFORMATION ***
(Billing Address)

Name:_____

Phone:_____

Address:_____

City/State/Zip:_____

E-Mail Address:_____

Relationship to Patient:_____

Contact you with visits/times/etc: Yes No

EMERGENCY CONTACT INFORMATION

Name:_____

Phone: _____

E-Mail Address:_____

Relationship to Patient: _____

Contact you with visits/times/etc.: Yes No

Name:_____

Phone: _____

E-Mail Address:_____

Relationship to Patient: _____

Contact you with visits/times/etc.: Yes No

PREVIOUS PHYSICIAN

Name: _____

Phone: _____

Last Apt. Date: _____

PHARMACY OF CHOICE

Name:_____

Phone:_____

OTHER INFORMATION

How did you hear about us? _____

Preferred Hospital: _____

DIRECT CARE OPTION
(Please choose one.)

Option	Price	√
1st Adult **Monthly**	$49/month	
Spouse **Monthly**	$39/month	
Child with Adult **Monthly**	$19/month	
Child without Adult **Monthly**	$39/month	
1st Adult **Annual**	$539/year	
Spouse **Annual**	$429/year	
Child with Adult **Annual**	$209/year	
Child without Adult **Annual**	$429/year	

***Patient's choosing the monthly option will be required to place a credit/debit card on file to be billed the first Monday of each month.**

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Medical History Form

Person Filling out Form:_____ Relationship to PT:_____

1. Current/Past Medical Problems:

□ Alzheimer's	□ Diabetes	□ Dialysis	□ Stroke/ TIA
□ Arthritis	□ Eye Disease	□ Liver Disease	□ Thyroid Disorder
□ Asthma	□ Gout	□ Multiple Sclerosis	□ Tuberculosis
□ Bleeding Tendency	□ Heart Attack	□ Muscular Dystrophy	□ Other: (Please List)
□ Blood Clot	□ Heart Failure	□ Neuropathy	□
□ High Cholesterol	□ Heart Rhythm Disorder	□ Polio	□
□ Chronic Bronchitis	□ Heart Valve Problem	□ Pulmonary Embolus	□
□ CO PD	□ High Blood Pressure	□ Seizure	□
□ Dementia	□ High Cholesterol	□ Sleep Apnea	D
□ Depression	□ Kidney Disease	□ Spinal Cord Injury	□

2. *Past Surgeries or Hospitalizations:*

Please mention any difficulty with Anesthesia

□ Amputation	□ Colonoscopy	□ Hysterectomy	□ Other: (Please List)
□ Angioplasty	□ Coronary	□ Other Vascular	□
□ Appendectomy	□ Gall Bladder Removal	□ Prostate Surgery	□
□ Cataract Surgery	□ Hernia	□ Tonsils	□

3. *Medical Allergies:*

□ NONE	□ Gluten Intolerance	□ Penicillin	□ Other: (Please List)
□ Aspirin	□ Iodine	□ Shellfish	□
□ Contrast	□ Latex	□ Sulfa	□
□ Food Allergies	□ Metal	□ Tape	□

4. Medications:

Please list both prescription and over the counter medications

Medications and Strength (mg or meg, etc.)	**How Often Taken or As Needed**
1.	
2.	
3.	
4,	
5.	
6.	
7.	
8.	
9.	
11.	

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5. Social History:

- Tobacco Use:
  Never _____
  Quit_____ Quite Date _____
  Current Smoker □ Packs per day on average: _____; Years smoked:_____
- Alcohol Use
  Never _____
  Quit_____
  Number of drinks per week_____

- Was drinking too much alcohol ever a problem for you: Yes or No
- Illegal Drug Use:

  Never _____ Quit_____ Quite Date_____

- Was drug use ever a habit for you: Yes or No

- Current Smoker No or Yes **If yes;** Packs per day on average:_____ Type _____

- Sexual Activity: Not currently ; □ Yes
- Past Occupation: _____; Years of Education _____
- Advance Directives:
- Durable Power of Attorney for Healthcare — Name and Relationship_____

  □ Living Will

  □ Do Not Resituate Form

  Would you like information on Advanced Directives: Yes or No

6. Immunizations:

If not known please contact your primary care doctor before our visit and ask if you are up-to-date on your immunizations.

Immunization	Yes	No	Unknown	Refuses
Influenza (Fin)				
Pneumococcal (Pneumonia)				

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Patient Name:_____(Please Print)

CONSENT FOR TREATMENT

I acknowledge and understand that, in presenting myself for treatment and continuing medical care with Care2u, that I authorize and consent to the administration and performance of all tests and treatments which may be ordered by the physician (and/or designated assistant) and carried out by members of the Care2u medical staff and personnel.

Minors must be accompanied by a parent/legal guardian for medical care except when the minor is seeking specific services for which they are not required to obtain parental consent, accompaniment or guidance, as clearly expressed by State law.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have received and have been presented with the opportunity to review the Care2u Privacy Notice prior to my initial visit. 1 understand that I may obtain a copy of any future revised Notices from Care2u by contacting the business office.

X_____ _____
Patient/Spouse/Nearest Relative/Legal Guardian **Date**

Reason that Notice was not accepted or patient/representative did not acknowledge receipt:

_____Patient indicates received on prior visit _____Patient declined to sign _____Other

_____Patient/Representative initials if declined _____ Employee initials (if patient/representative did *not accept*

AUTHORIZATION TO LEAVE MESSAGE

In completing and signing this form, I authorize that Care2u may leave a message containing medical information for a period of 12 months from the date signed on this form and as follows:

On my business/place of employment voice mail/answering machine Yes No
(Please circle)

On my home voice mail/answering machine Yes No
(Please circle)

On my cell phone voice mail # _____ Yes No
(Please circle)

In the space below, if so desired, please indicate any *personal representative/individuals who are permitted to receive or know information concerning your healthcare for the period 12 months from the date you sign this form. If your designated personal representatives change during the time this form is in effect, you must contact Care2u in writing and request the change. **Individual(s) I designate are as follows:**

_____

*A personal representative as defined under the Health Insurance Portability Act of 1996 (HIPAA) is any family member, friend or individual designated by the patient to whom the patient's health information may be disclosed. If you would like to change any of the information on this form, prior to the end of the time period stated above, you must contact Care2u in writing and request the change. This form must be up-to-date, signed and on file in your chart prior to any medical information being left on answering machines or with individuals you designate.

X _____ _____
Patient Name/Spouse/Nearest Relative/Legal Guardian **Date**

_____ _____
Witness **Date**

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Specified medical information will be released for the patient as indicated below, upon appropriate completion of this authorization._____

_____

_____ _____ _____ _____ _____
Last Name First Name MI Maiden/Other Name Date of Birth

_____ _____ _____ _____
Phone Number Street Address City and State Zip Code

In making a request for medical information, please check one of the two options below:

- ☐ You are the patient; the patient's designated personal representative or the patient's guardian.
- ☐ You are affiliated with Care2u and its member organization and so authorized to request medical information on behalf of the patient for further treatment. NOTE: Healthcare providers may request medical information from another provider for further treatment as codified at *45 CFR 164.506(b)2 and (c)2* of the HIPAA Privacy Rule,

Dates of Service Requested: From: _____/_____/_____ to :_____/_____/_____

Purpose of Release: (Required) ☐ Continuation of Care ☐ Personal Reasons ☐ Insurance ☐ Legal
☐ Other (Fill-in) _____

Release of Information from:

Name:_____

Address: _____

_____

Disclose the Information to:

Care2u Medical Services
1230 Hwy 70 E Suite 1
New Bern, NC 28560
252-514-6594 (Phone)
888-491-3407 (Fax)

Requested Medical Information (Check those that apply):

□ Emergency Record	□ Pathology Report	□ Psychosocial History	□ Physician Office Medical Record
□ Discharge Summary	□ Lab Reports	□ Cardiac Catheterization	□ Other_____
□ History and Physical	□ Physical Therapy, Occupational	Report	_____
□ Consultations	Therapy or Speech Therapy	□ Diagnostic Testing	_____
□ Progress Notes	□ Psychiatric Assessments	□ EKG/EEG Reports	
□ Report of Operation	□ Psychiatric Evaluation	□ Radiology Reports	
	□ Psychological Testing		

Note: While Care2u and its member organizations make every effort to protect the privacy of your medical information, please note that release of your medical information to the authorized person or organization could be the subject of re-disclosure by the recipient and therefore may no longer be protected by the Health Insurance Portability and Accountability Act ("HIPAA") or other federal or state laws. This authorization has no expiration date.

_____ _____ ____/_____/_____
Signature of Parent/Guardian (minors age 0-17) Relationship to Patient Date

_____ _____/_____/_____
Signature of Requestor Date

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Photography Consent Form

Patient Name: _____ Date of Birth: _____

I give my permission for the Care2u clinicians and staff to obtain photographs of me, my driver's license, and other documents deemed necessary. I understand that all photographs taken of me are part of my confidential medical record and will not be used or released to any other party without my written authorization. I understand that I can revoke this permission at any time by submitting my request to the Care2u office in writing.

_____ _____

Print Patient's Name **Date**