

Welcome to Cary Medical Group! Your time is valuable, and we feel that your being aware of the information found below will help your interactions with our office to be as efficient as possible.

Please arrive 20 minutes early for your first appointment with our office to complete necessary paperwork. New patient paperwork is also available on our website at carymedicalgroup.com. Please bring your insurance cards to every visit. Due to federal regulations, all patients will be required to present a photo I.D. upon request. **Payment of co-pays is expected at time of service.**

Our office is located at:
530 New Waverly Place,
Suite 200
Cary, NC 27518
Phone: **919-859-5955**
Fax: **919-859-5659**

EMERGENCY SITUATIONS / PHONE CALLS

If you are calling about an emergency situation, **please inform the operator immediately** so that your call will be handled appropriately.

Other phone calls will be returned during the course of the day as the schedule allows. Please remember that the physicians and nurses are seeing scheduled patients throughout the day, and it may take some time before a return call can be made. **The office functions with a timely and efficient message system, so it is not necessary to make repeat phone calls to the office during the course of a day.** Calls made after 3 p.m. may not be returned until the following day. Please be advised, your physician may bill for medical management over the telephone.
Simple Phone Consultation – \$15.00,
Intermediate Phone Consultation – \$25.00,
Complex/Lengthy Phone Consultation – \$35.00

APPOINTMENTS

- Upon scheduling the initial appointment, each patient will select a primary care provider within Raleigh or Cary Medical Group who will provide the majority of their care. Once established, transferring to another provider for routine care is not encouraged. However, if a sick visit is needed at a time your primary provider is not available, you will be scheduled to see another provider within the practice in which care has been established. If you need assistance after hours, please call the main number to Cary Medical Group (**919-859-5955**). Our answering service will contact the physician on call for Raleigh and Cary Medical Group to assist you.
- A Walk-in Sick Clinic is offered each day from 1-3 pm for established patients with minor acute illnesses such as cough, cold, sore throat, bladder infection and rash (a complete list of criteria for minor acute illnesses are displayed at the front check-in window). Patients coming to the Sick Clinic will be seen by the first available physician or PA. Please be advised, you may experience a wait time of up to 1 hour. If you would prefer to schedule a set appointment, you may do so by selecting the options for Same Day Appointments upon calling the office (919-859-5955).
- If you have several questions or problems that need to be discussed, this is best handled by scheduling an office visit.
- Physical exams should be scheduled at least 3 months in advance, as time slots are limited.

- As a reminder, you will receive a confirmation phone call for upcoming appointments.
- **Our office requires a 24 hour advance notice for the cancellations or rescheduling of an appointment.** This will allow us to offer that time to another patient. Please be advised, you may be charged a missed appointment fee, \$28.00 per 15 minute increments, if advance notice is not given. Repeated failure to keep your scheduled appointments may force us to have your medical care transferred elsewhere.
- Information updates are required every 6 months. Please have your insurance information readily available at check in to allow us to process your information update in a timely manner. We ask that you arrive 15 minutes early to complete this necessary paperwork.

PRESCRIPTIONS

- **Please request prescription refills directly from your pharmacist.** The pharmacist will use our prescription refill line to address your medication needs. This ensures that the nurse/physician will have the complete information needed to process your request. Plan on a 48-hour turn-around time for routine refills, and please call the pharmacy to see if the medication is ready. **The pharmacy line is for pharmacy calls only.** In the event that you leave a message on the pharmacy line, your request will not be processed.
- When you call for a refill, please try to call for all medications that need to be refilled within the next thirty days.

(prescriptions continued on next page)

- Please ask for refills of prescription medications that you keep on hand, such as allergy medications, when you come into the office for a routine visit.
- We will be happy to assist you with completion of paperwork for prescriptions that need to be processed through a mail-in pharmacy. However, it is the patient's responsibility to forward the paperwork or prescriptions to their pharmacy.

TEST RESULTS

- Routine lab results (those drawn to monitor an ongoing problem such as diabetes, elevated cholesterol or thyroid disease) will be **mailed** to you with instructions about continued treatment and the next scheduled follow-up. **Please allow 7-10 days for the mail to arrive.** We will call you with any abnormal labs that require an immediate change in treatment. Patients on blood thinners such as Coumadin or Warfarin will continue to be called with protime results.
- Notice of other normal findings such as pap smears, mammograms and hemocults will also be mailed.

REFERRALS

- Managed care referrals require a visit with your primary care physician first. Requests for follow-up visits to the specialist may sometimes be handled with a phone call. Please allow **at least two business days** to process referrals.
- **Retroactive referrals will not be issued.** If you have an HMO plan, and a specialist refers you to another physician or facility (such as physical therapy) you must contact our office for that referral.

Please remember that your referral cannot be processed until you contact our office with the above information. Failure to follow these instructions may result in your insurance company denying coverage for the specialist visit.

MEDICAL RECORDS REQUEST

- Please allow **7-10 business days** to complete requests for medical records. If you do not have a signed release on file, you will be asked to sign one when picking up your records. If you need records to be sent from another medical facility to this office, you will need to send a signed medical release to that office in order for the records to be released to Raleigh/Cary Medical Group. There may be a charge associated with copying records. Please contact our Medical Records Department for more information at 919-859-5955, ext. 3347.

BILLING

- If you have any questions regarding your account balance, please call 919-341-3552 for assistance. So that we

may better serve you, please have your physician's name and account number from your statement available.

REFUNDS

- Refunds are issued within thirty days of receipt of payment at Raleigh Medical Group. If you are aware of an account credit, please allow thirty days before contacting your account representative (919-341-3552).

FORMS

- If you have disability, DMV, FMLA or work/physical forms that need completion, you need to schedule an appointment to ensure that these forms are completed accurately and completely.
- Please be advised, there may be a charge for form completion. (Simple – \$25.00, Moderate – \$50.00, Complex – Minimum Charge \$75.00).

MORE INFORMATION

- Our website www.carymedicalgroup.com provides more information including our mission statement, billing information and links to reliable sources of medical information.
- We do not currently offer email communication. If you choose to fax information to us, please be advised that response time may be delayed, depending on the availability of your physician.

INSTRUCTIONS FOR SCHEDULING/ COMPLETION OF LAB WORK

- You will be scheduled to have your labs drawn on a specific date/time. It is important that you come on that scheduled date so the lab requisition will be completed appropriately in anticipation of your arrival. To schedule upcoming lab appointments, please contact Cary Medical Future Appointment Scheduling Department at 919-859-5955.
- You should report to LabCorp, 530 New Waverly Place, Suite 306, at your scheduled lab appointment time.
- For fasting lab tests, please do not eat or drink anything, other than water, 12 hours prior to your appointment. **If you are diabetic, please check with your physician before fasting. We encourage you to drink plenty of water.** You may take your medications prior to your lab visit unless a medication level is being measured (digoxin or seizure medication, for example. Your nurse will give you specific instructions if medication levels are to be drawn.
- **Please do not arrive on a date other than your scheduled day for your lab work.**

CURRENT MEDICAL PROBLEMS

Date of Onset

PAST MEDICAL PROBLEMS / HOSPITALIZATION / SURGERIES

Dates

FAMILY MEDICAL HISTORY: Please list all relatives diagnosed with any of the following conditions including their age at onset (please note if deceased).

Heart Disease: _____

Diabetes: _____

High Cholesterol: _____

Hypertension: _____

Colon Cancer: _____

Breast Cancer: _____

Ovarian Cancer: _____

Thyroid: _____

Other: _____

Additional Information: _____

SCREENINGS (date of last):

Mammogram: _____

Pap Smear: _____

Colonoscopy: _____

Bone Density: _____

PSA: _____

IMMUNIZATIONS (date received):

Tetanus: _____

MMR: _____

Hepatitis B: _____

Pneumovax: _____

PPD (Tb skin test): _____

Flu: _____

OTHER SPECIALISTS THAT YOU SEE ON A REGULAR BASIS (name and specialty):



SUMMARY OF NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

This notice is a description of how medical information about you may be used and disclosed and how you can get access to this information.

For additional information, please refer to the full version of this notice or contact our privacy officer.

Cary Medical Group
530 New Waverly Place,
Suite 200
Cary, NC 27518

Phone: **919-859-5955**

Fax: **919-859-5659**

USES AND DISCLOSERS OF YOUR PROTECTED HEALTH INFORMATION

We may use or disclose your health information:

- To treat you
- To get paid for treating you
- To run the Practice
- To remind you of appointments
- As may be required or otherwise permitted by law

For more information of how we may use or disclose your health information, please refer to the full version of this notice or contact our Privacy Officer.

We will use or disclose your health information for other purposes only with your authorization. If you authorize us to use or disclose your protected health information for other purposes, you may revoke that authorization at any time by notifying us.

YOUR RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION

You have a right to:

- Ask us to limit the information that we have
- Receive confidential communications from us regarding your health information
- Look at and obtain a copy of your health information
- Amend mistakes in your health information
- Obtain a list of disclosures of your health information that we have made; and
- Obtain a copy of the full version of our Notice of Privacy Practices

For more information on how to exercise your rights and how such rights may be limited by law, please refer to the full version of the Notice or contact our Privacy Officer.

OUR DUTIES WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION

We are required by law to maintain the privacy of your protected health information, to provide you with notice of our legal duties with respect to your protected health information and our privacy practices, and to abide by the terms of our Notice of Privacy Practices.

REVISIONS TO NOTICE OF PRIVACY PRACTICES

We may revise our policies with respect to the privacy of patient health information from time to time. An amendments to our Notice shall be posted in our offices, and copies of any amended Notice will also be available in our offices.

COMPLAINTS

If your believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. For more information on how to file a complaint, please refer to the full version of this Notice or contact our Privacy Officer.

PRIVACY OFFICER CONTACT INFORMATION

If you have any questions regarding your privacy rights, please refer to the full version of this Notice or contact our privacy officer at (919) 859-5955. You may also address questions of concerns to the privacy officer by writing to:

Privacy Officer
530 Waverly Place, Suite 200
Cary, NC 27518



530 New Waverly Place, Suite 200, Cary, NC 27518 Phone: 919-859-5955 Fax: 919-859-5659

HIPAA AUTHORIZATION FORM

Chart #: _____ Date: _____

I give my permission for the providers of Cary Medical Group (a division of Raleigh Medical Group, P.A.) to release ANY information about my medical condition, prescriptions, and financial account to:

Name: _____

Name: _____

Name: _____

Below, I give my permission for the providers of Cary Medical Group (a division of Raleigh Medical Group, P.A.) to release prescriptions, samples, forms and medical records to:

Name: _____

Name: _____

Name: _____

The above mentioned person(s) **will be required to provide photo ID** when picking up requested items.

Patient name: _____ Date of birth: _____

Patient signature: _____

By signing on the line below, I acknowledge that I was provided access to the Notice of Privacy Practices of Cary Medical Group.

Print Name: _____ Date of birth: _____

Patient Signature: _____

For Personal Representation of the Patient (if applicable)

Print Name of Personal Representative: _____

Representative's Relationship (i.e. parent/guardian/other, etc.): _____

Signature of Personal Representative: _____

_____ I refuse to acknowledge I was provided access to the Notice of Privacy Practices of Cary Medical Group (a division of Raleigh Medical Group, P.A.).

Signature of Practice Employee Date

PATIENT REGISTRATION (please print)



1. Chart Number _____

2. Patient's Full Name _____ 3. Sex: M F
Last First Middle Name Preferred

4. Race: (Please Circle) American Indian, Asian, African American, Native Hawaiian or Pacific Islander, Caucasian, Other, Patient Declined
Ethnicity: (Please Circle) Non-Hispanic, Hispanic, Patient Declined

5. Patient's Social Security # _____ 6. Date of Birth: _____ Age: _____

7. Patient's Home Address _____
Street or Route City State Zip
Patient's Email Address _____

8. Primary Care Doctor _____ 9. Financial Responsibility: Patient Other

10. Referring Doctor _____

11. Patient's Home Phone (____) _____ Patient's Work Phone (____) _____ Patient's Cell Phone (____) _____

12. Is the Patient Currently Employed? Yes No
Patient's Employer _____
Employer's Address _____
Street or Route City State Zip

13. Patient's Marital Status S M D W Sep. Spouse Name _____

14. Person we may contact in case of an emergency: Relationship _____
Name _____ Phone # _____
Address _____
Street or Route City State Zip

INSURANCE INFORMATION – We cannot file your insurance without complete information and a copy of your insurance cards. Please bring your insurance card with you to the front desk when you have completed this form.

PRIMARY INSURANCE COVERAGE

15. Insurance Company _____ Address _____

16. Subscriber's Name _____ 17. Subscriber's Sex: M F

18. Subscriber's Date of Birth _____ 19. Subscriber's Social Security # _____

20. Patient's Relationship to Subscriber Self Spouse Child Other

21. Subscriber's Employer _____

22. Subscriber's ID # _____ 23. Group # _____

SECONDARY INSURANCE COVERAGE

24. Insurance Company _____ Address _____

25. Subscriber's Name _____ 26. Subscriber's Sex: M F

27. Subscriber's Date of Birth _____ 28. Subscriber's Social Security # _____

29. Patient's Relationship to Subscriber Self Spouse Child Other

30. Subscriber's Employer _____

31. Subscriber's ID # _____ Group # _____

OTHER INSURANCE Yes No

FINANCIAL AGREEMENTS AND AUTHORIZATION FOR TREATMENT: I hereby authorize Raleigh Medical Group, Cary Medical Group, Raleigh Adult Medicine and Wake Endoscopy Center ("RMG/CMG/RAM/WEC") and its physicians and such assistants as a physician may designate to furnish and perform on me or the patient stated above ("Patient") such medical care, examination and treatment as may be ordered by an RMG/CMG/RAM/WEC physician in his or her medical judgment and such medical care, examination or treatment as is reasonable incident thereto. I hereby authorize direct payment to RMG/CMG/RAM/WEC of all medical insurance benefits (including without limitation Medicare and Medicaid benefits) to which the Patient is entitled in consideration of services to be rendered by RMG/CMG/RAM/WEC to the Patient. I understand that, to the extent permitted by applicable law, I am and I agree hereby to be, financially responsible to RMG/CMG/RAM/WEC for charges not covered by this agreement, and I hereby guarantee payment to RMG/CMG/RAM/WEC on demand for all such charges.

Signature _____ Please check one: Patient Authorized Representative
 Parent or Guardian of Minor

Date _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize RMG/CMG/RAM/WEC to furnish, to the extent permitted by applicable law, any medical information acquired in the course of the Patient's examination and/or treatment to any insurance company, government agencies and their agents, and professional review organizations with which the Patient may have insurance coverage or which may be assisting in payment of the medical care provided by RMG/CMG/RAM/WEC to the Patient. I also hereby authorize RMG/CMG/RAM/WEC to release any medical information to any licensed physician, health care provider, or medical facility to which the Patient may be referred, admitted, or transferred for further medical care. I understand that I may revoke this authorization by written notice at any time except to the extent that action has been taken.

Signature _____ Please check one: Patient Authorized Representative
 Parent or Guardian of Minor

Date _____



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FROM CARY MEDICAL GROUP

Please Print Patient's Full Name			Birth Date: Month	Day	Year
Street Address			Social Security Number		
City	State	Zip	Phone (home number)		

At the request of the individual, I _____, do hereby authorize Cary Medical Group to release:
(Patient's name)

- | | | |
|---|---|--|
| <input type="checkbox"/> DISCHARGE SUMMARY | <input type="checkbox"/> PATHOLOGY REPORTS | <input type="checkbox"/> EMERGENCY REPORTS |
| <input type="checkbox"/> HISTORY & PHYSICAL | <input type="checkbox"/> LABORATORY REPORTS | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> PROGRESS NOTES | <input type="checkbox"/> RADIOLOGY REPORTS | _____ |
| <input type="checkbox"/> OPERATIVE NOTES | <input type="checkbox"/> ECG/EEG/CARDIAC CATH | _____ |

I DO I DO NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASED TO:

Name of Company/Agency/Facility/Person

Street Address

City, State, ZIP

PURPOSE OF DISCLOSURE:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> REFERRAL TO SPECIALIST | <input type="checkbox"/> INSURANCE | <input type="checkbox"/> WORKER'S COMP | <input type="checkbox"/> CHANGE OF DOCTOR |
| <input type="checkbox"/> LEGAL INVESTIGATION | <input type="checkbox"/> DISABILITY DETERMINATION | <input type="checkbox"/> PERSONAL | <input type="checkbox"/> CONTINUING CARE |
| <input type="checkbox"/> OTHER (SPECIFY) _____ | | | |

Please provide current telephone number in the event we need to contact you: _____

I hereby authorized disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized/furnished may not condition its treatment of me on whether or not I sign the authorization..

Signature of individual or guardian or Personal Representative of patient's estate

Date

NOTE: THERE WILL BE A CHARGE FOR RECORDS. \$0.75 PER PAGE FOR THE FIRST 25 PAGES. \$0.50 PER PAGE THEREAFTER WITH A MAXIMUM OF \$25.00 PER REQUEST PLUS POSTAGE WHEN REQUESTING RECORDS FOR PERSONAL USE OR PERMANENT TRANSFER.



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO CARY MEDICAL GROUP

Please Print Patient's Full Name Birth Date: Month Day Year

Street Address Social Security Number

City State Zip Phone (home number)

At the request of the individual, I _____, do hereby authorize _____ to release: (Patient's name)

- _____ DISCHARGE SUMMARY _____ PATHOLOGY REPORTS _____ EMERGENCY REPORTS
- _____ HISTORY & PHYSICAL _____ LABORATORY REPORTS _____ OTHER _____
- _____ PROGRESS NOTES _____ RADIOLOGY REPORTS _____
- _____ OPERATIVE NOTES _____ ECG/EEG/CARDIAC CATH _____

I DO I DO NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASED TO: CARY MEDICAL GROUP
530 New Waverly Place, Suite 200
Cary, NC 27518

PURPOSE OF DISCLOSURE:

- _____ REFERRAL TO SPECIALIST _____ INSURANCE _____ WORKER'S COMP _____ CHANGE OF DOCTOR
- _____ LEGAL INVESTIGATION _____ DISABILITY DETERMINATION _____ PERSONAL _____ CONTINUING CARE
- _____ OTHER (SPECIFY) _____

Please provide current telephone number in the event we need to contact you: _____

I hereby authorized disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized/furnished may not condition its treatment of me on whether or not I sign the authorization..

Signature of individual or guardian or Personal Representative of patient's estate Date

ENTIRE _____ LAB _____ EKG _____
DS _____ EKG _____ IMMUNE _____
OP _____ X-RAY _____ OTHER _____
HP _____ PATH _____
NUMBER OF PAGES _____
Medical Records Technician
Date