Blue Ridge Family Physicians, LLC
Communications Preference Form

Notice to patients: Use this form to make a request to BRFP that we communicate with you by the alternative means or locations.

In order for BRFP to respond promptly and accurately to your request, please complete this form entirely.

Patient Name ______________________ Date of Birth ______________

Primary contact number (______)____________ Secondary contact number (______)____________

Address ____
City State Zip

Email ____
Home Work

How would you prefer to communicate with BRFP? Check and number for all that apply

Yes	No		Yes	No	
____	____	Phone – Primary	____	____	Email address
____	____	Phone – Primary	____	____	US Mail (home address

Where can we leave a message or an appointment reminder?

____ ____ Phone – Primary

____ ____ Phone – Secondary

Please initial the following

______ I understand that some sensitive information (HIV, STD, abnormal lab results and diagnoses) will not be left as a message nor be discussed over the phone.

______ I understand that I will have to fill out a PATIENT PROXY/REPRESENTATIVE form to authorize another person to communicate with the practice on my behalf.

______ I have reviewed and I understand this form.

Patient Signature ______________________________ Date ____________

For Personal Representative of the Patient (If applicable):______________________

Print Name of Representative ______________________________

Relation to Patient ______________________________

I hereby certify that I have the legal authority under applicable law to make this request on behalf of the patient identified above.

Signature of Patient Representative ______________________ Date ____________

Blue Ridge Family Physicians New Patient Questionnaire

Name ______________________________ Date__________ Account Number (office use) __________

1. Are you allergic to any medications?________If so, 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?______________
   If so, which ones and how much per day?____________________ and week____________________?

4. Date of last: Chest X-ray____________ TB Skin Test__________ Result________
   Blood Test____________ Eye Exam______________
   Tetanus Shot____________ Electrocardiogram__________
   Women Only: Last Menstrual Period__________ Pap Smear__________ Mammogram__________

5. **Past Medical Hospitalizations:**
   Date Reason
   ____
   ____
   ____
   ____

Past Surgery:
Date Reason
____
____
____
____

Current Medications (Include prescribed medications, over-the-counter, vitamins, sleep aids, laxatives etc.)

MEDICATION	DOSE	FREQUENCY TAKEN	MEDICATION	DOSE	FREQUENCY TAKEN

6. Family History: Please check if a blood related member of your family has had any of the following:
   ☐TB ☐Heart Disease ☐Bleeding Tendency ☐Rheumatic Fever ☐High Blood Pressure ☐Anemia
   ☐Diabetes ☐Strokes ☐Arthritis ☐Thyroid Disease ☐Lung Disease ☐Mental Disease ☐Cancer
   ☐Kidney Disease ☐Glaucoma other disease:______________________________

Blue Ridge Family Physicians New Patient Questionnaire

Name ______________________________ Date__________ Account Number (office use) ___________

	Age(if living)	Age at Death (if deceased)	State of Health If not good, state reasons	Cause of Death
Mother				
Father				
Brother(s) No. Alive___ Dead___				
Sister (s) No. Alive___ Dead___				
Children No. Alive___ Dead___				

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

____

8. List any chronic diseases you have:____

____

9. Signature of person completing this form:____________________________ Date ___________

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Blue Ridge Family Physicians, PLLC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPROTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in the Notice while it is in effect. This Notice takes effect **April 14, 2003**, and will remain in effect until we replace it.

We reserve the right to change our privacy and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOUSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operation, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us written authorization, you may revoke it in writing at anytime. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare, but only if you agree we may do so.

Persons involved in care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure or your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counter intelligence, and other national security activities. We may disclose to correctional institution or a law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies on a format other than photocopies. We will use a format you request unless we cannot practicably do so. You must request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request copies, we will charge you **$0.75** for each page and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclose your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last six years, but not before April 14, 2003. If you request this accounting more than once in a 12 month period, we may charge you a cost-based fee for these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use of disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in emergencies).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make this request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information (Your request must be in writing and it must explain why the information should be amended). We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site of by electronic mail, you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns. Please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we have made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternate means or at alternate locations. You may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Service upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact: Telephone: 787-3448 .//. Fax: 232-0006
Address 2605 Blue Ridge Road Suite 300 Raleigh, NC 27607

Blue Ridge Family Physicians, PLLC

NOTICE OF PRIVACY RECEIPT

I acknowledge that I was provided by the Notice of Privacy for Blue Ridge Family Physicians.

Name of Patient: ______________________________

Patient's date of birth ________/________/________

Signature of Patient: ______________________________

Date: ________________

Personal Representative of the Patient (if applicable):

Name of Personal Representative: ______________________________

Relationship to Patient: ______________________________

Signature of Patient Representative: ______________________________

Date: ________________

______________________________ ________________

Signature of Practice Employee Date

Blue Ridge Family Physicians, PLLC

Patient Information Form

Patients Name ____________________ Maiden Name ____________ Date of Birth ________

Best Contact Number (____)______________ Alternate Number (____)______________

Home Address ____

Social Security Number __________________ Drivers License Number ________________

Email Address ____

Employer ______________________ Work Number (____)________________

Spouse's Name ______________________ Spouses Number (____)________________

Whom may we contact in case of an emergency?

Name ______________________ Phone Number (_____)________________

Relationship to Patient __________________

Who is responsible for the bill?

Name ______________________ Phone Number (_____)________________

Address ____

Relationship to Patient __________________

Authorization to release Medical Information:

I authorize that my medical information can be left on my answering machine ____ yes ____ no

I understand and agree that (regardless of my insurance status); I am ultimately responsible for the balance of my account for my professional services rendered. I have read the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes to the above information.

______________________________ ______________

Signature Date

______________________________ ______________

Parent Signature (if minor) Date

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Blue Ridge Family Physicians, PLLC
Patient Representative Authorization/Proxy Form

This form allows you to choose a patient representative (a designated person authorized by you) that allows Blue Ridge Family Physicians to disclose/share your medical Information. (Example: Spouse, Parent, Family member, or any person of your choice) You may place limitations on the type of information that is to be disclosed, or choose not to select a representative.

- PATIENT NAME: ______________________________
  (Please print clearly)
- PATIENT DOB: ______________________________

Please check one:

☐ **I DO NOT wish to select a patient representative at this time.**

☐ **I DO wish to select a patient representative at this time.**

I ____________________ designate ____________________
(State relationship to patient) ____________________ as my representative. My signature below acknowledges that I give my authorization for Blue Ridge Family Physicians, PLLC to disclose any and all medical information pertaining to my care to the above named representative.

***Please indicate any restrictions/limitations of medical information to be shared with your representative:**

____
____
____
____
____

My designated representative can be reached:
Phone (Home) ______________ Work ______________ Cell ______________

__ I have reviewed and I understand this form.
__ I understand that I can withdraw my consent in writing at any time.

Patient Signature: ______________________________ **Date:** ______________

A more recent signed proxy will supersede any previous signed consent forms.