You may reach us after hours by calling (828) 257-4730 for any of our facilities

WELCOME TO OUR PRACTICE

We are happy you have chosen MAHEC Family Health Centers for your care!

We are a group practice offering care for the entire family where patients of all ages can establish their care. We are a primary care medical home, meaning our team of healthcare professionals work together to provide all of your healthcare needs. You, the patient, are the most important part of a patient-centered medical home. We strive to provide evidence-based care in a professional, supportive atmosphere. Our providers look forward to an on-going relationship with you and an exceptional patient experience at every appointment.

Our full-spectrum family healthcare services include

- Primary care for children, adults and older patients
- Family-centered obstetrics including lactation consultation for breastfeeding support
- Sports medicine
- Family therapy and individual counseling
- Free interpreter services
- Geriatric medicine
- Hep C/HIV treatment
- Positive parenting program (Triple P)
- Integrated clinical pharmacy support, laboratory services and X-Rays
- Medication for opioid use disorder and substance abuse recovery support
- No-scalpel vasectomies and other procedures
- Nutritional counseling with registered dietitians including pediatric healthy weight medical visits
- IDD clinical care
Welcome to MAHEC!

Thank you for choosing us for your healthcare. MAHEC has been a part of Asheville since 1974 and we proudly continue our tradition of award-winning care. Our providers and staff welcome the opportunity to care for your entire family at our Family Health Centers, Internal Medicine office, OB/GYN offices, Dental offices and Center for Psychiatry. We proudly serve all patients regardless of income or insurance status.

- MAHEC is expanding our financial assistance program to go above and beyond what we have offered before. In order to facilitate this change we are asking all existing and new patients to complete a new patient information packet.
- Our Patient Financial Advocates are available to guide you through signing up for assistance offered through our Sliding Scale Discount Program. Eligibility is based on family income and family size. Payment is expected at time of service for amounts you are responsible for. We can assist with payment options if you are unable to pay in full.

BEFORE YOUR VISIT

This welcome packet includes forms you need to read and complete before your visit.

It is **VERY** important that you fill out each form completely and give the entire packet to the front desk staff when you arrive for your appointment. Please arrive **15 minutes before your appointment** to complete the check-in process.

Other documentation you need to bring with you:
- Insurance card and driver’s license (or other valid photo ID)
- Pertinent medical history or records
- Current List of medications or medication bottles
  - Drug name
  - Prescribed dosage(s)
  - How long you have been taking the drug(s)

MAHEC’s Patient Portal

We are pleased to provide all patients with an online tool that provides 24/7 access to your personal health record. With the portal, you can securely email your provider, see lab results, review your medical records and much more. We will use the email address you provide to give you access to the portal if you don’t currently have it. Just watch for an email with instructions that will come to you after your appointment.

*Thank you for choosing us for your healthcare!*

Mountain Area Health Education Center

[www.mahec.net](http://www.mahec.net)
Who may we speak with?

This form will allow MAHEC to discuss your medical and financial information about the care and services you have received with individuals of your choosing. This form does not allow the listed individuals to obtain copies of your medical or financial information. You may list up to three (3) individuals below OR choose not to list anyone. You can update this form at any time.

Your name (please print) ______________________________________________________________

Your date of birth: ______________________________________________________________

Person #1 that we can speak with

Name: __________________________________________________________________

Relationship: ____________________________ Phone #: ______________________

Person #2 that we can speak with

Name: __________________________________________________________________

Relationship: ____________________________ Phone #: ______________________

Person #3 that we can speak with

Name: __________________________________________________________________

Relationship: ____________________________ Phone #: ______________________

OR

☐ I do not wish to list anyone at this time.

__________________________________________  ________________________
Signature of patient, parent, or legal guardian    Date
MAHEC Patient Registration Form

Please complete the following information using black ink. THIS INFORMATION IS CONFIDENTIAL.

Race (select one):
- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian
- Native Hawaiian
- Other Pacific Islander
- Guamanian/Chamorro
- Samoan
- Black/African American
- American Indian/Alaska Native
- White
- More than one race

Ethnicity (select one):
- Mexican/Mexican American/Chicano
- Puerto Rican
- Cuban
- Hispanic/Latino/Spanish
- Non-Hispanic/Latino/Spanish

Gender Identity:
- Male
- Female
- Transgender Male
- Transgender Female
- Other
- Choose not to disclose

Sexual Orientation:
- Lesbian or Gay
- Heterosexual (or straight)
- Bisexual
- Something else
- Don’t know
- Choose not to disclose

Preferred Language:
- English
- Spanish
- Russian
- American Sign Language
- Other: ____________________________

By providing a phone number, mobile phone number, or email address, I authorize MAHEC to contact me or my guardian/legal representative to remind me of appointments, to obtain feedback on my experience at this office, and to provide general health reminders and other information regarding my healthcare.

Special Hearing Needs:

Special Vision Needs:

Uses Wheelchair: □ Yes □ No
Speech Impaired: □ Yes □ No
Veteran Status: □ Yes □ No

Marital Status:
- Single
- In a relationship
- Partner
- Married
- Separated
- Divorced
- Widowed

Special Populations
Migratory □ Yes □ No
Seasonal □ Yes □ No
Homeless □ Yes □ No

Homeless Status (select one):
- Not Homeless
- Homeless Shelter
- Transitional
- Doubling Up
- Street
- Permanent Supportive Housing
- Other

June 2023 | Page 1 of 3
I hereby authorize payment of all insurance, Medicaid, and/or Medicare benefits directly to MAHEC and I authorize them to file
insurance on my behalf. I also authorize them to release medical and/or account information to my insurance, Medicaid, and/or
Medicare carrier as required to satisfy claims. I agree to notify them should my coverage change.

I understand that MAHEC:

• Expects payment on the date of service (if insured, co pays and deductibles are expected on the date of service).
• Accepts cash, checks, debit cards or major credit cards.
• Expects Medicaid, Medicare and all insurance will be filed for me. However, it is my responsibility to know the details of my
insurance coverage and provide MAHEC with current and accurate information.
• Will work with me to establish payment plans.
• Provides services and treatment, which are medically appropriate. However, some of these may not be covered by my
insurance plan and these will be my responsibility to pay.
• Expects my insurance company to pay within 90 days from the date of service and will bill me directly if the insurance does
not pay.
• Expects the parent or guardian to pay for all services rendered to their dependents.
• Expects me to keep appointments and to call at least 24 hours prior, if I need to cancel. I understand that failure to do this may
result in being discharged from the practice.

I have read and understand the above.

Patient or Parent/Guardian Signature: ___________________________ Date: ________________

Note: Failure to sign does not relieve you of the above expectations.
CONSENT FOR TREATMENT

I voluntarily consent to routine services, medical treatment(s), diagnostic radiology procedure(s), diagnostic lab(s), behavioral health services, and services offered by lay health workers (e.g. doula, community health worker, peer support specialist) as deemed necessary by the healthcare providers treating me at any MAHEC facility. I voluntarily consent to allow MAHEC to seek emergency medical care from a physician or hospital, if needed. I understand that diagnostic procedures may include but are not limited to lab tests on blood, urine, and tissue, including drug screenings. I understand that diagnostic radiology procedures include but are not limited to x-ray, ultrasound, and/or mammography. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may cause injury or even death. I understand I have the right to ask questions about my treatment and/or procedures and the right to refuse any treatment or procedure. I agree to notify my provider of my concerns.

Patient or Parent/Guardian Name (please PRINT): ____________________________

Patient or Parent/Guardian Signature: ____________________________ Date: ____________

NOTICE OF PRIVACY ACKNOWLEDGMENT

I have been given the opportunity to read MAHEC’s Notice of Privacy Practices, and my questions concerning the Notice have been answered. I understand if I choose not to sign this acknowledgment, MAHEC will continue to provide services to me and will use and disclose my Protected Health Information (PHI) in accordance with MAHEC’s Notice of Privacy Practices.

Patient or Parent/Guardian Signature: ____________________________ Date: ____________

FOR OFFICE USE ONLY

Primary Care Provider: ________________________________________________

Copy of insurance card obtained? □ Yes □ No
New Patient Intake Form

Patient Name: ____________________________ Date of Birth: ____________

Form Completed by: ____________________________ Date of Today’s Visit: ____________

Have you received medical care from another physician in the last 5 years?  ☐ Yes  ☐ No  If yes, please give name and location.

Physician name: ____________________________________________
Physician city and state: ______________________________________

What is the reason for your visit today? ____________________________

ALLERGIES

Do you have any allergies or bad reactions to medicines, foods or latex?  ☐ Yes  ☐ No  If yes, please list them below.

Medicine, food, latex or other substance: ____________________________
Reaction caused: ______________________________________________

MEDICATIONS

Please list ALL medications you currently take (including birth control pills, vitamins, supplements and herbs) even if you do not take them every day, and even if they are over the counter.

Name of medication, vitamin, herb or supplement: ____________________________
Dosage (ex: how many mg or tablets you take): ____________________________
How often you take it: ______________________________________________

Are you taking a multivitamin with folic acid?  ☐ Yes  ☐ No

Local Pharmacy: ____________________________ Mail Order: ____________________________

MEDICAL HISTORY

Have you ever had any the following? Please check the boxes of all that apply to you.

☐ Alcohol abuse                  ☐ Cancer, other: ____________________________
☐ Anemia                        ☐ COPD/Emphysema                          ☐ History of physical abuse  ☐ Thyroid trouble
☐ Anxiety                       ☐ Depression                               ☐ History of sexual abuse  ☐ Other:
☐ Arthritis                     ☐ Diabetes                                ☐ Irritable Bowel Syndrome
☐ Asthma                        ☐ Drug Abuse                               ☐ Kidney disease
☐ Attention Deficit Disorder    ☐ GERD/Reflux                             ☐ Kidney stones
☐ Bipolar Disorder             ☐ Heart attack, when: __________________
☐ Bladder problems             ☐ Heart failure                            ☐ Migraines
☐ Blood clots                  ☐ Hepatitis, choose: ☐ A ☐ B ☐ C           ☐ Osteoporosis
☐ Breast cancer, when: __________ ☐ High blood pressure                   ☐ Seizures
☐ Colorectal cancer, when: __________  ☐ High cholesterol                   ☐ Sexually Transmitted Disease

☐ High blood pressure

July 2021
SURGICAL HISTORY
What surgeries or procedures have you had? Please check the boxes of all that apply to you.

☐ Amputation, where: ___________________________ Year: ________  ☐ Hernia repair  ☐ Left ☐ Right Year: ________

☐ Appendix removed Year: ________  ☐ Knee surgery  ☐ Left ☐ Right Year: ________

☐ Artificial joints, where: ___________________________ Year: ________  ☐ Neck surgery  ☐ Left ☐ Right Year: ________

☐ Back surgery Year: ________  ☐ Ovaries removed  ☐ Left ☐ Right Year: ________

☐ Breast surgery  ☐ Left  ☐ Right Year: ________  ☐ Stress test of heart Year: ________

☐ Cataract extraction  ☐ Left  ☐ Right Year: ________  ☐ Tonsils removed Year: ________

☐ Catheterization of heart Year: ________  ☐ Tubes tied Year: ________

☐ Gall bladder removed Year: ________  ☐ Uterus removed Year: ________

☐ Heart surgery Year: ________  ☐ Vasectomy Year: ________

Description of surgery or any other surgeries you have had: ___________________________

REPRODUCTIVE HISTORY
How many pregnancies have you had? ______  Number of live births: ______  Number of living children: ______

Number of C-Sections: ______  Number of miscarriages: ______  Number of still births: ______  Number of abortions: ______

Menopause (‘change of life’) since: ____________

IMMUNIZATION HISTORY
Are your childhood vaccinations up to date?  ☐ Yes  ☐ No  ☐ Unsure  Have you had the following vaccines?

Flu (this year)  ☐ Yes  ☐ No  Date: ________  Pertussis (“whooping cough”)  ☐ Yes  ☐ No  Date: ________

Hepatitis B  ☐ Yes  ☐ No  Date: ________  Shingles  ☐ Yes  ☐ No  Date: ________

Pneumonia (Prevnar)  ☐ Yes  ☐ No  Date: ________  Tetanus  ☐ Yes  ☐ No  Date: ________

Pneumonia (Pneumovax)  ☐ Yes  ☐ No  Date: ________  COVID  ☐ Yes  ☐ No  Brand: __________ Date: ________

Others: ___________________________  ☐ Yes  ☐ No  Date: ________

FAMILY MEDICAL HISTORY
Please indicate if your mother (m), father (f), sister (sis), brother (b), daughter (d), son (son) has a history of the following.

☐ Alcohol abuse  Who? ________  ☐ High blood pressure  Who? ________

☐ Anesthesia complications  Who? ________  ☐ High cholesterol  Who? ________

☐ Anxiety  Who? ________  ☐ Kidney disease  Who? ________

☐ Asthma  Who? ________  ☐ Lung problems  Who? ________

☐ Blood clots  Who? ________  ☐ Melanoma  Who? ________


☐ Colon cancer, how old: ____________  Who? ________  ☐ Osteoporosis  Who? ________

☐ Cancer, other: ___________________________  Who? ________  ☐ Other mental illness  Who? ________


☐ Eczema  Who? ________  ☐ Thyroid trouble  Who? ________

☐ Heart attack, how old: ____________  Who? ________  ☐ Other: ___________________________ Who? ________

If your father is deceased, how old was he when he died? ______  What did he die from? ___________________________

If your mother is deceased, how old was she when he died? ______  What did she die from? ___________________________

July 2021
SOCIAL HISTORY

Please indicate your marital or relationship status.
- Single
- Married since: ________________
- Not married, living together since: ________________
- Separated since: ________________
- Divorced since: ________________
- Widowed since: ________________

What is your gender identity? ________________

SEXUAL HISTORY

Are you sexually active?  □ Yes  □ No
What is the gender of your sexual partner(s)? ________________
Age you became sexually active: ________________
Number of sexual partners in the last year: ________________
What is your sexual orientation? ________________

ALCOHOL & DRUG USE

On average, how many alcoholic beverages do you drink per week? ________________

Men under 65: How many times in the past year have you had 5 or more drinks in a day?
- None
- 1 or more

Women (and men over 65): How many times in the past year have you had 4 or more drinks in a day?
- None
- 1 or more

How many times in the past year have you used a recreational drug or a prescription medication for non-medical reasons?
- None
- 1 or more

TOBACCO USE

- I have never used tobacco
- I have smoked, started at age: ________________
- I still smoke ____ packs per day
- I quit _____ (date) but used to smoke ____ packs per day
- I have tried to quit _____ times
- I chew or use smokeless tobacco
- I vape or use e-cigarettes
- I am exposed to second-hand smoke

The following people make up my household.

Name: __________________________________________ Year born: _______ Relation to me: ______________
Name: __________________________________________ Year born: _______ Relation to me: ______________
Name: __________________________________________ Year born: _______ Relation to me: ______________
Name: __________________________________________ Year born: _______ Relation to me: ______________
Name: __________________________________________ Year born: _______ Relation to me: ______________
Name: __________________________________________ Year born: _______ Relation to me: ______________

HEALTHY HABITS

In general, how many days do you exercise per week? ______
On those days, how long do you exercise? ______ minutes
When you exercise, what is the intensity?
- Mild (stretching or slow walking)
- Moderate (brisk walking)
- Heavy (jogging or swimming)
- Vigorous (fast running or stair climbing)
- Combination

Do you drink caffeine daily?  □ Yes  □ No
If yes, how many servings of the following per day?
____ cups of coffee  ____ energy drinks  ____ tea

TOBACCO USE

- I have smoked, started at age: ________________
- I still smoke ____ packs per day
- I have tried to quit _____ times
- I quit _____ (date) but used to smoke ____ packs per day

The following people make up my household.

Name: __________________________________________ Year born: _______ Relation to me: ______________
Name: __________________________________________ Year born: _______ Relation to me: ______________
Name: __________________________________________ Year born: _______ Relation to me: ______________
Name: __________________________________________ Year born: _______ Relation to me: ______________
Name: __________________________________________ Year born: _______ Relation to me: ______________
Name: __________________________________________ Year born: _______ Relation to me: ______________

July 2021
REPRODUCTIVE LIFE PLANNING
Would you like to become pregnant in the next year?
- Yes
- No
- Okay either way
- Unsure
Are you using any method to prevent pregnancy?
- Yes
- No
If yes, what: __________________________________________
Do you use condoms?  Yes  No

COLORECTAL HEALTH
Date of most recent colonoscopy: __________________________
Date of other colorectal cancer screening: ___________________

ADVANCED CARE PLANNING
Have you filled out forms to indicate your desires for end of life care?
Living Will:  Yes  No
Durable power of attorney for healthcare (“DPOA”):  Yes  No
If yes, who: ____________________________________________

COMPREHENSIVE REVIEW OF SYSTEMS
Please check the boxes of any symptoms you have had in the past 2 weeks.

General
- Fatigue
- Fever
- Loss of appetite
- Unplanned weight gain
- Unplanned weight loss

Skin
- New sore or lesion
- Non-healing sores
- Rash

Eyes/Ears/Nose/Throat/Mouth
- Began wearing glasses or contacts
- Change in vision
- Bad teeth
- Dentures
- Frequent stuffy nose
- Hearing loss
- Hoarseness
- Nose bleeds
- Ringing in ears
- Seasonal allergies
- Sinus pain
- Snoring

Lungs
- Breathing problems
- Cough
- Coughing up blood
- Wheezing

Breasts
- Breast lump
- Breast pain

Cardiovascular
- Chest pain or pressure
- Heart beats fast
- Heart skips
- Short of breath with exercise
- Short of breath lying down
- Waking at night short of breath
- Swelling or edema

Gastrointestinal
- Abdominal pain
- Black tarry stool
- Blood in stool
- Change in bowel habits
- Constipation
- Diarrhea

Gastrointestinal, continued
- Difficulty swallowing
- Heartburn
- Nausea
- Vomiting

Genitourinary
- Bleeding after menopause
- Blood in urine
- Difficulty holding urine
- Difficulty urinating
- Excessive urination at night
- Pain or burning with urination
- Sexual health concerns
- Trouble with periods

Muscles and Skeleton
- Backache
- Muscle pain
- Painful joints

Endocrine
- Excessive thirst
- Hot flashes

Neurological
- Fainting or passing out
- Headaches
- Memory loss
- Numbness or tingling
- Sense of room spinning
- Tremor
- Unsteadiness or imbalance
- Weakness

Mental Health
- Change in sleep pattern
- Feeling nervous, anxious or on edge

Blood
- Easy bleeding
- Easy bruising
- Swollen glands

Other: __________________________________________________

DEPRESSION SCREENING (PHQ-2)
Over the past two weeks, how often have you been bothered by the following problems?

Not at all  Several days  More than half of the days  Nearly every day

Little interest or pleasure in doing things:
- 0  1  2  3

Feeling down, depressed or hopeless:
- 0  1  2  3

July 2021
SLIDING SCALE DISCOUNT PROGRAM

*Compassionate financial support*

It is the policy of MAHEC to provide essential services for Medical, Behavioral Health, and Dental Care regardless of the patient’s ability to pay. Discounts are offered based on family size and annual income.

The discount will apply to all essential services provided and billable by MAHEC. Services performed by outside organizations and equipment that is purchased from outside companies, including outside laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services, will not be covered under this policy. This form must be completed every 12 months or if your financial situation changes.

The application can be completed online by using the QR codes below, or you can request a paper application from any front desk team member.

These documents will need to be turned in before your application can be processed: Completed Application and Proof of Income

Applications need to be received within 30 days of your first appointment.

**Family Health Centers**
Financial Advocate
Phone: (828) 771-5502  |  Fax: (828) 579-4208

Mailing Address:
123 Hendersonville Rd, Asheville, NC  28803

**Center for Psychiatry and Mental Wellness**
Financial Advocate
Phone: (828) 771-5466  |  Fax: (828) 579-4212

Mailing Address:
125 Hendersonville Rd, Asheville, NC  28803

**Ob/Gyn Specialists**
Financial Advocate
Phone: (828) 771-5443  |  Fax: (828) 407-2639

Mailing Address:
119 Hendersonville Rd, Asheville, NC  28803

**Dental Health Centers**
Financial Advocate
Phone: (828) 398-5918  |  Fax: (828) 552-8691

Mailing Address:
123 Hendersonville Rd, Asheville, NC  28803

**Internal Medicine**
Financial Advocate
Phone: (828) 771-3507  |  Fax: (828) 579-3748

Mailing Address:
123 Hendersonville Rd, Asheville, NC  28803

If you have any questions regarding this program, please feel free to contact your Patient Financial Advocate
COMPLETE ALL SECTIONS, DATE, AND SIGN  

I authorize the use or disclosure of the above named individual’s health information as described below.

<table>
<thead>
<tr>
<th>The information is to be disclosed by:</th>
<th>And is to be provided to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME OF FACILITY:</td>
<td>MAHEC Centralized Medical Records Department</td>
</tr>
<tr>
<td></td>
<td>Family Medicine ❯ OB/Gyn ❯ Internal Medicine</td>
</tr>
<tr>
<td></td>
<td>Dental ❯ Psychiatry</td>
</tr>
<tr>
<td>ADDRESS:</td>
<td>121 Hendersonville Road</td>
</tr>
<tr>
<td>CITY/STATE:</td>
<td>Asheville, NC 28803</td>
</tr>
<tr>
<td>PHONE #:</td>
<td>FAX #:</td>
</tr>
</tbody>
</table>

The purpose or need for this disclosure is:

I understand that the information released may include sensitive information related to behavior and/or mental health, drugs and alcohol (including records of a program that provides alcohol or drug abuse diagnosis, treatment, or referral, as defined by federal law at 42 CFR Part 2), rape, abuse (sexual, physical, elder, spousal, etc.) abortion, sexual diseases like HIV/AIDS and other communicable disease and genetic testing.

Information to be disclosed: (check appropriate box(es))

- Standard release (last 3 years of notes, lab/x-ray reports, med list, allergy list, immunization record, consult notes.)
- Only information related to (specify): _____________________________________________________________________
- Only the period of events from: _______________________________ to __________________________________
- Entire medical record
- Exclusions    AIDS/HIV test results, diagnosis, treatment, and related information
  - Drug screen results and information about drug and alcohol use and treatments
  - Mental health notes
  - Genetics testing

I understand that this authorization will expire 90 days from the date it is signed unless I have specified a different expiration date or expiration event as follows. ____________________________________________________________

I understand that I may cancel this authorization at any time by notifying in writing the MAHEC Privacy Officer, 121 Hendersonville Road Asheville, NC 28803, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.

I understand that information used or disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state laws.

I understand that MAHEC will not condition treatment or eligibility for care on the provision of this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

By signing below, I acknowledge that I have read and understand this Authorization.

SIGNATURE OF PATIENT>Date

SIGNATURE OF AUTHORIZED REPRESENTATIVE PATIENT, IF APPLICABLE (State relationship to Patient) > DATE

WITNESS TO SIGNATURE, IF APPLICABLE > DATE

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.