WELCOME TO OUR PRACTICE

We are happy you have chosen MAHEC Internal Medicine for your care!

Our practice is designed to provide comprehensive care for adults including the diagnosis, treatment, and prevention of disease. We focus on delivering high quality and thoughtful medical care to patients from late adolescence through geriatrics. Our comprehensive approach provides care for short and long term (chronic) illnesses, acute issues, and age based preventive care.

Our top notch staff may call you to gather information before your visit. This allows our providers to focus more on your active problems at the visit. If our staff are unable to reach you before the appointment, we ask that you fill out the attached new patient history forms and bring them to your appointment. This will help us see you more efficiently on the day of your appointment.

OFFICE HOURS

Monday - Friday 8:00 am - 5:00 pm

If you are an established patient and have a true emergency after hours, please go to your nearest Emergency Department. You may also reach our after-hours service at 828-771-3500. Please note that we do not prescribe controlled substances on the first visit or after hours.

MAHEC Internal Medicine
Mary C. Nesbitt Biltmore Campus, 125 Hendersonville Road, Asheville, NC 28803
Phone: 828-771-3500 | Fax: 828-412-4171
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
MAHEC Patient Registration Form

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

☐ Internal Medicine  ☐ FHC Biltmore  ☐ FHC Cane Creek  ☐ FHC Enka/Candler  ☐ FHC Newbridge
☐ Ob/Gyn Biltmore  ☐ Ob/Gyn Franklin  ☐ Women’s Care Brevard  ☐ Psychiatry  ☐ Deerfield  ☐ Givens

PATIENT INFORMATION

Name: ______________________ Date of Birth: ______________________
Home Address: ____________________________
City: __________________ State: _______ ZIP: ____________
Home County: __________________ Email Address: __________________
Home Phone: __________________ Cell Phone: __________________

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

Race (select one):
☐ Asian
☐ Native Hawaiian
☐ Other Pacific Islander
☐ Black/African American
☒ American Indian/Alaska Native  ☐ White
☐ More than one race

Ethnicity (select one):
☐ Hispanic or Latino/a
☐ Non-Hispanic or Latino/a

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: ____________________________

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

EMERGENCY CONTACT INFORMATION

Name: ____________________________
Relationship: __________________ Phone#: __________________

IF PATIENT IS CHILD (UNDER 18)

Responsible Party Name: ____________________________
Relationship: __________________ Phone#: __________________
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 Signature: ________________________________ Date: ________________________________

ALTERNATIVE CONTACT AUTHORIZATION

I authorize MAHEC to discuss medical and financial information concerning the care and services provided to me with the individuals listed below:

Contact #1
Name: __________________________________________________________
Relationship: __________________________ Phone#: __________________________

Contact #2
Name: __________________________________________________________
Relationship: __________________________ Phone#: __________________________

Contact #3
Name: __________________________________________________________
Relationship: __________________________ Phone#: __________________________

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: ________________________________
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: ____________________________
______________________________
______________________________

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: __________________________________________
______________________________

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: ____________________________
______________________________
______________________________
______________________________
______________________________
______________________________

Local Pharmacy: ____________________________ Mail Order: ____________________________

MEDICAL HISTORY
Have you ever had any of the following? Please check the boxes of all that apply to you.
☐ Alcohol abuse  ☐ Cancer, other: ____________________________  ☐ History of physical abuse  ☐ Thyroid trouble
☐ Anemia  ☐ COPD/Emphysema  ☐ History of sexual abuse  ☐ Other: ____________________________
☐ Anxiety  ☐ Depression  ☐ Irritable Bowel Syndrome  ☐ ________________
☐ Arthritis  ☐ Diabetes  ☐ Kidney disease  ☐ ________________
☐ Asthma  ☐ Drug Abuse  ☐ Kidney stones  ☐ ________________
☐ Attention Deficit Disorder  ☐ GERD/Reflux  ☐ Migraines  ☐ ________________
☐ Bipolar Disorder  ☐ Heart attack, when: ________________  ☐ Osteoporosis  ☐ ________________
☐ Bladder problems  ☐ Heart failure  ☐ Seizures  ☐ ________________
☐ Blood clots  ☐ Hepatitis, choose: □ A  □ B  □ C  ☐ Sexually Transmitted Disease  ☐ ________________
☐ Breast cancer, when: ________________  ☐ High blood pressure  ☐ Skin cancer, when: ________________
☐ Colorectal cancer, when: ________________  ☐ High cholesterol  ☐ Stroke  ☐ ________________

October 2021
Surgical History
What surgeries or procedures have you had? Please check the boxes of all that apply to you.

- [ ] Amputation, where: ____________________ Year: ________
- [ ] Appendix removed Year: ________
- [ ] Artificial joints, where: ____________________ Year: ________
- [ ] Back surgery Year: ________
- [ ] Breast surgery [ ] Left [ ] Right Year: ________
- [ ] Cataract extraction [ ] Left [ ] Right Year: ________
- [ ] Catheterization of heart Year: ________
- [ ] Gall bladder removed Year: ________
- [ ] Heart surgery Year: ________
- [ ] Hernia repair [ ] Left [ ] Right Year: ________
- [ ] Knee surgery [ ] Left [ ] Right Year: ________
- [ ] Neck surgery Year: ________
- [ ] Ovaries removed [ ] Left [ ] Right Year: ________
- [ ] Stress test of heart Year: ________
- [ ] Tonsils removed Year: ________
- [ ] Tubes tied Year: ________
- [ ] Uterus removed Year: ________
- [ ] Vasectomy Year: ________

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

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? ________
- Asthma Who? ________ [ ] Lung problems Who? ________
- Cancer, other: __________ Who? ________ [ ] Other mental illness Who? ________
- Depression Who? ________ [ ] Prostate cancer, how old: __________ Who? ________
- Diabetes, how old: __________ Who? ________ [ ] Seizures 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 she died? ________ What did she die from? ____________________

October 2021
Patient Name: ___________________________  Date of Birth: ______________________

SOCIAL HISTORY
Please indicate your marital or relationship status.
☐ Single  ☐ Married since: _________________________
☐ Not married, stable partner 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? _________________________

<table>
<thead>
<tr>
<th>Men under 65:</th>
<th>Women (and men over 65):</th>
</tr>
</thead>
<tbody>
<tr>
<td>How many times in the past year have you had 5 or more drinks in a day?</td>
<td>How many times in the past year have you had 4 or more drinks in a day?</td>
</tr>
<tr>
<td>☐ None  ☐ 1 or more</td>
<td>☐ None  ☐ 1 or more</td>
</tr>
</tbody>
</table>

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

OCCUPATION
☐ Currently employed at: _________________________  Doing: _________________________  Since: _________________________
☐ Homemaker since: _________________________
☐ Retired since: _________________________
☐ Former job: _________________________
☐ Disabled due to: _________________________  Since: _________________________

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

COLORECTAL HEALTH
Date of most recent colonoscopy: _________________________
Was it normal?  ☐ Yes  ☐ No
Date of other colorectal cancer screening: _________________________
Was it normal?  ☐ Yes  ☐ No

WOMEN’S HEALTH
Have you ever had an abnormal pap test?  ☐ Yes  ☐ No
When was your last pap? _________________________
Was it normal?  ☐ Yes  ☐ No
When was your last mammogram? _________________________
Was it normal?  ☐ Yes  ☐ No
When was your last bone density (DEXA) scan? _________________________
Was it normal?  ☐ Yes  ☐ No

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
- □ Fevers
- □ Loss of appetite
- □ Unplanned weight gain
- □ Unplanned weight loss

Skin
- □ New sore or lesion
- □ Non-healing sores
- □ Rashes

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
- □ Constipation
- □ Diarrhea
- □ 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

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
**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**COMPLETE ALL SECTIONS, DATE, AND SIGN**

<table>
<thead>
<tr>
<th>Patient Name: __________________________________________</th>
<th>Date of Birth: __________________</th>
</tr>
</thead>
</table>

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 Internal Medicine</td>
</tr>
<tr>
<td></td>
<td>Centralized Medical Records Dept.</td>
</tr>
<tr>
<td>ADDRESS:</td>
<td>123 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.**

<table>
<thead>
<tr>
<th>SIGNATURE OF PATIENT</th>
<th>DATE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>SIGNATURE OF AUTHORIZED REPRESENTATIVE PATIENT, IF APPLICABLE (State relationship to Patient)</th>
<th>DATE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>WITNESS TO SIGNATURE, IF APPLICABLE</th>
<th>DATE</th>
</tr>
</thead>
</table>

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