WELCOME TO OUR PRACTICE

We are happy you have chosen us for your care!

All of our providers and team members look forward to welcoming you to our practice! We have enclosed the necessary paperwork for you to complete before your visit.

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

AFTER HOURS
Providers are on call and you can leave a message for the provider by calling the office number and choosing the prompt for the on-call service. This should be used for urgent matters only. Non urgent calls such as appointment scheduling and medication refill requests should be made during office visits or by calling the office during business hours. For mental health and medical emergencies, you should call 911 or reach out to RHA Mobile Crisis Services at 888-573-1006.

OUR COMPREHENSIVE MENTAL HEALTH SERVICES INCLUDE

- Medication Management
- Psychotherapy
- Intellectual and developmental disabilities (IDD) behavioral health support
- Substance use disorder treatment
- Medication for opioid use disorder
- Transcranial Magnetic Stimulation (TMS)
- Peer Support Services
- Collaborative Care Management Programs
- School Based Therapy
- Acceptance and commitment therapy
- Cognitive behavioral therapy
- Mindfulness-based stress management
- On-site laboratory services
- Parent-child interaction therapy
- Play therapy
- Long acting injectable medication support
- Trauma-informed 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
NEW PATIENTS
New patients need to bring completed paperwork, a picture ID and insurance cards to first appointment. Patients are encouraged to contact their insurance company and verify mental health benefits prior to their first visit. We accept all insurance, but this does not guarantee that we are in network with your plan.

RETURNING PATIENTS
Returning patients should make sure all information is up to date at each visit. This includes name, address, phone number and insurance information.

TELEPHONE CONSULTATIONS
Telephone consultations are generally not available. Please discuss your healthcare needs during your visit. Should issues arise between appointments please contact our office to schedule an earlier appointment.

AFTER HOURS
One of our providers will be on call and you can leave a message for the provider by calling the office number and choosing the prompt for the on-call service. This should be used for urgent matters only. Non urgent calls such as appointment scheduling and medication refill requests should be made during office visits or by calling the office during business hours. For medical emergencies, you should call 911.

PRESCRIPTION REFILLS
All medication refill requests need to be made during the patient’s appointment. Please bring prescription bottles or a list of medications with you to each appointment. Prescription refill requests at other times will be completed within 3 business days.

BILLING
You are responsible for your annual deductible, co-pay/co-insurance, and any balance that your insurance does not pay. Co-pays are expected at the time of service. Please be aware that some services are not covered by insurance and you will be billed. We accept cash, check, and credit card payments. A service fee is assessed for returned checks. The billing office phone number is (828) 257-4725, option 3. If you have a billing question, please call the billing office and we will do our best to help you or direct you to someone who can.

I have read and agree to the above policy:

_________________________________________________               ___/____/____              _____________________
Printed Name                Date of Birth        Today’s Date

_________________________________________________
Signature

Thank you for choosing us for your healthcare!
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: ________________________________  Birth Sex: ☐ Male  ☐ Female
City: ________________________________  State: ______  ZIP: ____________  SS#: ________________________________
Home County: ________________________________  Email Address: ________________________________
Home Phone: ________________________________  Cell Phone: ________________________________  Work 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  ☐ No  ☐ Yes
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  ☐ 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  ☐ Yes  ☐ No
☐ Seasonal  ☐ Yes  ☐ No  ☐ 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#: ________________________________
ANNUAL HOUSEHOLD INCOME BEFORE TAXES

# of Individuals in Household: __________

The income information above is used for statistical information only and is not used to determine specific patient financial needs.

---

PRIMARY INSURANCE INFORMATION

Insurance Company: ________________________ Policy ID#: ________________________

Policy Holder’s Name: ________________________ Policy Holder’s DOB: __________

Policy Holder’s Relationship to Patient: ________________________ Birth Sex of Policy Holder: □ Male □ Female

Policy Holder’s Address: ________________________

SECONDARY INSURANCE INFORMATION

Insurance Company: ________________________ Policy ID#: ________________________

Policy Holder’s Name: ________________________ Policy Holder’s DOB: __________

Policy Holder’s Relationship to Patient: ________________________ Birth Sex of Policy Holder: □ Male □ Female

Policy Holder’s Address: ________________________

ASSIGNMENT OF BENEFITS AND FINANCIAL POLICY

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: ___________________________

FOR OFFICE USE ONLY

Primary Care Provider: ________________________________________________

Copy of insurance card obtained? □ Yes □ No
Patient Name: ___________________________ Date of Birth: ______________________

Form Completed by: _______________________________________________________

**ALLERGIES**

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

<table>
<thead>
<tr>
<th>Medicine, food, latex or other substance:</th>
<th>Reaction caused:</th>
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</table>

**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.

<table>
<thead>
<tr>
<th>Name of medication, vitamin, herb or supplement:</th>
<th>Dosage (ex: how many mg or tablets you take)</th>
<th>How often you take it:</th>
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</table>

Local Pharmacy: ____________________________________________

**FAMILY MEDICAL HISTORY**

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? ________________________________________

**SURGICAL HISTORY**

Please list the date(s) and description(s) of any past surgeries you have had:

<table>
<thead>
<tr>
<th>Date(s)</th>
<th>Description</th>
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</table>

**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: ____________________________

**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: ________________________________________
MEDICAL HISTORY
Please check the box if you have ever been diagnosed with or experienced the following.

- Alcohol Use Disorder
- Anemia
- Arthritis
- Asthma
- Bladder Problems
- Blood Clots
- Cancer - Breast
- Cancer - Colorectal
- Cancer - Skin
- Cancer - Other, please specify
- COPD/Emphysema
- Diabetes
- Drug Use Disorder
- GERD/Reflux
- Heart Attack
- Heart Failure
- Hepatitis A
- Hepatitis B
- Hepatitis C
- High Blood Pressure
- High Cholesterol
- History of Physical Abuse
- History of Sexual Abuse
- Irritable Bowel Syndrome
- Kidney Disease
- Kidney Stones
- Migraines
- Osteoporosis
- Seizures
- Sexually Transmitted Disease
- Stroke
- Thyroid Trouble
- Hypothyroidism
- Other, please specify

Please specify the other health condition(s).
___________________________________________________________________________________________________

Please specify the location of cancer.
___________________________________________________________________________________________________

Please specify when you experienced cancer.
___________________________________________________________________________________________________

Please specify when you had a heart attack.
___________________________________________________________________________________________________
**FAMILY MEDICAL HISTORY**

Please check the appropriate box if any of your blood-relatives have been diagnosed with or experienced the following mental health problems.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Mother</th>
<th>Father</th>
<th>Sister</th>
<th>Brother</th>
<th>Daughter</th>
<th>Son</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Use Disorder</td>
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<tr>
<td>Anxiety Disorder or Panic</td>
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<tr>
<td>Autism Spectrum Disorder</td>
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<tr>
<td>Bipolar Disorder, Manic Episodes, or Manic Depressive Disorder</td>
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<tr>
<td>Drug Use Disorder</td>
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<tr>
<td>Eating Disorder</td>
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<tr>
<td>Intellectual or Developmental Disability</td>
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<tr>
<td>Major Depression or Clinical Depression</td>
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<tr>
<td>Obsessive-Compulsive Disorder</td>
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<tr>
<td>Personality Disorder</td>
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<tr>
<td>Post-Traumatic Stress Disorder</td>
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<tr>
<td>Psychiatric Hospitalization</td>
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<td>Schizophrenia, Schizoaffective Disorder, or another Paranoid or Delusional Disorder</td>
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<tr>
<td>Suicide Attempt</td>
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<tr>
<td>Completed Suicide</td>
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</table>

Other Mental Health Condition (please specify) ____________________________
Thank you for applying to our Sliding Scale Discount Program!

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

Please return all documents to your Patient Financial Advocate within 30 days of your first appointment.

Family Health Centers and Internal Medicine
Financial Advocate
Phone: (828) 771-3507
Fax: (828) 407-2640
Mailing Address:
123 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

Center for Psychiatry and Mental Wellness
Financial Advocate
Phone: (828) 771-3460
Fax: (828) 820-8327
Mailing Address:
125 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

If you have any questions regarding this program, please feel free to contact your Patient Financial Advocate at the numbers listed above.

Thank You!
Sliding Scale Discount Program

Compassionate financial support

Sliding Fee Discount Application

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. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

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.

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>DATE OF BIRTH</th>
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<tr>
<th>STREET ADDRESS</th>
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</table>

<table>
<thead>
<tr>
<th>CITY</th>
<th>STATE</th>
<th>ZIP</th>
<th>PHONE</th>
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<tbody>
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</table>

Please list spouse and dependents

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of birth</th>
<th>Needs Sliding Scale</th>
<th>Current MAHEC patient</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
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<td></td>
<td></td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
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</tbody>
</table>
Annual Household Income for all working adults

<table>
<thead>
<tr>
<th>Source</th>
<th>Self</th>
<th>Spouse</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last two pay stubs, tax form with schedule C if you are self-employed, or letter from employer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other other miscellaneous sources</td>
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</tbody>
</table>

NOTE: Copies of tax returns, pay stubs, or other information verifying income are required before a discount is approved.

I certify that the family size and income information shown above is correct.

Name (please print) _______________________________________________________ Date ____________

Signature _________________________________________________________________________________

Office Use Only

Approved by: ____________________________________________________________________________

Date approved: ___________________________________________________________________________

Family size: _____________________________________________________________________________

Income: _________________________________________________________________________________

Approved discount: _______________________________________________________________________

Date received signed agreement: ____________________________________________________________

Verification Check List

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identification/Address: Driver’s license, utility bill, employment ID, or</td>
<td></td>
</tr>
<tr>
<td>Income: Prior year tax return, two most recent pay stubs, or other</td>
<td></td>
</tr>
</tbody>
</table>
**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

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

| Patient Name: | __________________________ | Date of Birth: __________________________ |

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

| The information is to be disclosed by: | And is to be provided to: |
| NAME OF FACILITY: | MAHEC Center for Psychiatry  
Centralized Medical Records Dept. |
| ADDRESS: | 125 Hendersonville Road |
| CITY/STATE: | Asheville, NC 28803 |
| PHONE #: | FAX #: |

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.