NORTHRIVER
PRIMARY CARE ASSOCIATES

4310 Watermelon Road Northport, AL 35476
Phone: (205) 330-5266 Fax: (205) 330-9915

Provider Preference:	Dr McEntyre	Dr Kemp
	Amy Wyatt	Cacyce Fowler

NEW PATIENT APPLICATION & PAPERWORK

Today's Date	

Patient Name	Preferred Name to be called

Street Address	Apt #, Suite #, Lot #

City	State	Zip

Home Phone #	Cell Phone #	Work Phone #

Preferred Contact Method	Preferred Appointment Reminder Method
☐ Home Phone ☐ Cell Phone	☐ Home Phone ☐ Cell Phone ☐ Text

SSN	Sex	Date of Birth	Age
	☐ M ☐ F		

Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Widow/Widower

Ethnicity
☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer

Race ☐ American Indian/Alaska Native ☐ Black or African American ☐ Asian
☐ Hispanic ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Decline to Answer

Employment Status
☐ Full time ☐ Part time ☐ Self employed ☐ Unemployed ☐ Military ☐ Retired

Occupation	Employer

Preferred Language	Name & Phone # of Interpreter, if used
☐ English ☐ Other_____	

Email Address	Driver's License #

Emergency Contact **NOT** Living with Patient	Relationship to Patient

Contact's Primary Phone #	Alternate Phone #

Date: _____ Patient Name: _____ DOB: _____

INSURANCE INFORMATION	
Name of Primary Insurance:	**Name of Secondary Insurance**
Contract #/Member ID	Contract #
Group #	Group #
Name of Policy Holder	Name of Policy Holder
Policy Holder Date of Birth	Policy Holder Date of Birth
Relationship of Policy Holder to Patient	Relationship of Policy Holder to Patient

If Patient is a MINOR (18 or younger), we must have the following information

Person responsible for account			Relationship to Patient
Street Address			Apt #
City	State		Zip
Home Phone #	Cell Phone #		Work Phone #
SSN	Sex ☐ M ☐ F	Date of Birth	Age
Email Address			Driver's License #

If 26 years or younger and you are a dependent on the Insurance listed above, please complete the following information

Mother's Name	Mother's Address	
Phone Number	SSN	Date of Birth
Father's Name	Father's Address	
Phone Number	SSN	Date of Birth

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: We are required by law to make a good faith effort to provide you with our Notice of Privacy Practices and to obtain an acknowledgement of its receipt from you. By signing below, you agree that you either received a copy of our Notice of Privacy Practices or were offered a copy and declined to take one. A copy of our Notice of Privacy Practices is displayed in the clinic. You may request a copy of the Notice at any time.

CONSENT FOR TREATMENT: I consent to necessary treatment, including drugs, medicine, procedures, x-rays, lab tests and/or other studies that may be used by the physician, the nurse, or staff.

AUTHORIZATION FOR RELEASE OF INFORMATION: I understand that my information may be given to the insurance company with whom I have coverage, agencies which may be assisting with payment for my care, billing agencies, agencies responsible for reviewing payments and/or quality of care, and other governmental agencies. I give permission for release of this information.

ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to NorthRiver Primary Care Associates, of benefits otherwise payable to me including major medical insurance and payment of medical benefits, but not to exceed the charges of NorthRiver Primary Care Associates for these services. I understand that I am financially responsible to NorthRiver Primary Care Associates for charges not covered by this assignment. I authorize the refund of overpaid insurance benefits where my coverages are subject to coordination of benefits.

GUARANTEE OF ACCOUNT: In consideration of medical services rendered, the undersigned accepts all fees charged as lawful debt and agrees to pay NorthRiver Primary Care Associates insurance notwithstanding, for all said charges. Furthermore, undersigned agrees to pay the costs of collection including reasonable attorney's fees and court costs if such be necessary, waiving now and forever the right of exemption allowed to the constitution of laws of the State of Alabama or any other state. Undersigned further understands that NorthRiver Primary Care Associates does not accept insurance assignment as a guarantee of full payment.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA): I consent to the use or disclosure of my protected health information (HPI) by NorthRiver Primary Care Associates for the purpose of diagnosis or providing treatment to me, obtaining payment for my healthcare bills, or to conduct healthcare operations. I have received a copy of the Company's Notice of Privacy Practice. The Notice describes the types of disclosures of my PHI that will occur in my treatment, payments of my bills, or in the performance of healthcare operations of the Company.

COMMUNICATION: **I give my direct consent to receive communications from NorthRiver Primary Care Associates Staff, Servicers and the collectors of my account through various means including (1) cell phone (2) land line (3) email address (4) text message (5) auto dialer system (6) voicemail message and (7) other means of communication.

CONSENT TO OBTAIN ELECTRONIC MEDICATION HISTORY: I understand that my medication history may be obtained utilizing an electronic information exchange and that this PHI may provide valuable information for my healthcare provider. I hereby authorize physicians to access my medication history without limitation or exclusion as is required and/or reasonably advisable to disclose, process, retrieve, transmit, and view for the purpose of the transmission of an electronic prescription issued by a provider authorized by law to prescribe, as necessary for my care and treatment.

Patient Name: _____ Patient Date of Birth: _____

Patient Signature: _____ Date: _____

Responsible Party: Relationship to Patient: _____

NORTHRIVER
PRIMARY CARE ASSOCIATES

Financial Policies and Procedures

Insurance:

You must bring your insurance card(s) to every visit and inform us of any changes as they occur.

NorthRiver Primary Care Associates participates with various insurance companies. We will be happy to assist you, but it is the patient's responsibility to know your insurance benefits, copays, deductibles and whether our physician is in network with your insurance policy(ies). Most insurances will not pay for everything. If a service is non-covered, the fees will become the responsibility of the patient or guarantor. All copays, deductibles or non-covered charges are due at the time of service regardless of who brings the patient in for his/her visit. We gladly accept Cash, Check, Visa, Mastercard, Discover and American Express as forms of payment. There is a 3.5% processing fee added to all credit transactions.

Private Pay:

If you are currently uninsured, NorthRiver Primary Care Associates requires an initial payment of $100.00, due on the date of service, that will be put towards the charges for your visit. You will be billed for any remaining balance of services rendered.

Billing Policy:

As a courtesy, we will gladly file your office visit claim to your insurance company. Once your insurance has paid, any patient balances remaining will be billed to the patient or responsible party. If you are unable to make your payment in full, we ask that you contact our billing office to discuss a payment plan. If your balance remains unpaid for 90 days we may, at our discretion, turn your account over to an outside collection agency. You will be responsible for the fees assessed by the collection agency. This outstanding debt may also be listed with local, regional, or national credit-reporting agencies and may have a negative effect on the granting of future credit.

All lab work sent to one of our reference labs for testing, will be billed separately by the reference lab that performs the testing. All DCH labs must go to DCH for testing & All Select Lab tests must go to Quest. Please alert the front & nursing staff of your insurance.

Minors:

If a patient is a minor (18 years or younger), the parent or guardian is responsible for any payment due at time of service. Please understand that both parents are financially responsible for payment on the account under all circumstances.

Returned Checks:

If your check is returned to NorthRiver Primary Care Associates unpaid, a $30.00 returned check fee will be assessed in addition to the amount of the returned check. We can only accept cash or credit card payments for the returned check and fee. Both the check amount and fee must be paid together. If left unpaid, your check will be turned over to the Worthless Check Unit for collection.

Completion of Forms:

There is a fee and a 48-hour waiting period for all medical forms. Please do not ask the physician to complete forms in the room or leave them with him. All forms must be reviewed for accuracy and completion and we need to have a copy for your file. Please check with our office staff in advance on the cost(s) of each request. Also, to release any medical records, we must have a release of information signed by the patient or parent/guarantor. Due to HIPAA regulations, when picking up records/information, please bring your Driver's License or ID for verification.

Appointment Cancellation:

Please give a 24-hour notice if you are unable to make your appointment. There will be a charge of $25.00 for appointments that are not cancelled. There will be a charge of $50.00 for all weight loss appointments with CMWL that are not cancelled.

Prescriptions:

We will refill your prescription as soon as we are able but please allow a 48-hour turnaround time. No routine prescriptions will be called in at night or on the weekend. There is a charge for prescriptions that must be printed.

Patient Signature: _____ Date: _____

Date: _____ Patient Name: _____ DOB: _____

PAST MEDICAL HISTORY (Please check any condition(s) that you have currently or have ever had in the past.)

Cardiovascular
- o Abdominal aortic aneurysm
- o Anemia
- o Angina
- o Aortic stenosis
- o Atrial fibrillation
- o Blood clots
- o Carotid stenosis
- o Congestive Heart Failure
- o Coronary Artery Disease
- o DVT (Deep Vein Thrombosis)
- o Heart Attack/MI
- o High blood pressure
- o High cholesterol
- o Mini-strokes
- o Pacemaker
- o PE (Pulmonary Embolism)
- o Peripheral vascular disease
- o Stroke
- o Valve Disease

Derm
- o Abscesses
- o Acne
- o Eczema o Melanoma o Psoriasis
- o Skin Cancer (specify) _____

Endocrine
- o Diabetes, on insulin
- o Diabetes, on pills
- o Diabetes, Type I
- o Diabetes, Type II
- o Diabetic Neuropathy
- o Gout
- o High blood sugar
- o Hyperthyroidism
- o Thyroid problems

GI
- o Appendicitis
- o Cirrhosis
- o Colon Cancer o Crohn's Disease o Diverticulitis
- o Diverticulosis
- o Gallstones
- o GERD (reflux)
- o Hiatal hernia
- o Irritable Bowel Syndrome o Live disease o Pancreatitis
- o Peptic Ulcer Disease
- o Stomach ulcer
- o Ulcerative Colitis

GU Male
- o BPH (Benign prostatic hypertrophy)
- o Epididymitis
- o Erectile Dysfunction
- o Prostate Cancer
- o Prostatitis
- o STD
- o Testicular problems

GU Female
- o Breast cancer
- o Cervical cancer
- o Ectopic pregnancy
- o Ovarian cancer
- o Ovarian cyst
- o Pelvic Inflammatory Disease
- o STD
- o Urinary Incontinence

HEENT
- o Allergic rhinitis
- o Allergies
- o Cataracts
- o Glaucoma
- o Hearing Deficit
- o Vision Deficit

Infections
- o Hepatitis
- o HIV/AIDS
- o STD
- o Syphilis
- o Tuberculosis/ TB

Musculoskeletal
- o Osteoarthritis
- o Osteopenia
- o Osteoporosis
- o Rheumatoid Arthritis
- o Rotator cuff tear

Neuro/Psych
- o ADHD
- o Alcohol abuse
- o Alzheimer's disease
- o Anxiety
- o Autism
- o Bipolar disorder
- o Brain cancer
- o Dementia
- o Depression
- o Eating Disorder
- o Fibromyalgia
- o Headaches
- o Migraines
- o Parkinson's disease
- o Schizophrenia
- o Seizures
- o Substance abuse

Renal
- o Dialysis
- o End Stage Renal Disease
- o Kidney cancer
- o Kidney stones
- o Nephrotic Syndrome
- o Renal cell carcinoma
- o Renal failure or insufficiency

Respiratory
- o Asthma
- o COPD
- o CPAP use
- o Emphysema
- o Lung Cancer
- o Sleep Apnea

Other
- o _____
- o _____
- o _____

FOR WOMEN: # of pregnancies: _____# of births: _____ # children currently alive: _____

Do you desire to get pregnant? YES _____ NO _____ Age at menopause: _____

Age at first period? _____ When was your last menstrual cycle? _____

Date: _____ Patient Name: _____ DOB: _____

CURRENT MEDICATIONS: (Prescriptions AND Over-The-Counter)

Medication	Dose	Frequency	Who prescribed medication?

FOOD/DRUG ALLERGIES (Please list your reaction to each)

SPECIALISTS: What Specialists do you see? (Cardiologist, Dermatologist, Eye Doctor, etc.)

Name of Doctor/Practice	Specialty	Condition for which they treat you

Date: _____ Patient Name: _____ DOB: _____

SURGICAL HISTORY/HOSPITALIZATIONS

Year	Name of illness/operation/injury

FAMILY HISTORY: (Please check if any of your blood relatives have had any of the following)

- o Alcoholism
- o Asthma
- o Atherosclerosis
- o Autoimmune disease
- o Blood disorder
- o Heart problem
- o Heart disease
- o Dementia
- o Depression
- o Diabetes mellitus
- o Drug abuse
- o Hearing problems
- o Hepatitis B
- o High cholesterol
- o High blood pressure
- o Kidney disease
- o Mental illness
- o Obesity
- o Rheumatoid disease
- o Stroke
- o Thyroid disease
- o Tuberculosis
- o Vision problems
- o Cancer (specify) _____
- o Other _____

Relation	Still Living?	Health Problems/Cause of Death
Mother	Yes or No	
Father	Yes or No	
Sister(s)	Yes or No	
Brother(s)	Yes or No	

HEALTH HABITS:

1. Do you currently smoke? _____ YES _____ NO (If No, please skip to question 4)
2. How long have you been a smoker? _____
3. How many packs a day do you smoke? _____
4. Have you ever been a smoker? YES _____ NO (If No, please skip to question 7)
5. How long were you a smoker? _____
6. How many packs a day did you smoke? _____
7. Do you use smokeless tobacco? YES _____ NO
8. Do you regularly drink alcohol? YES _____ NO (If No, please skip to question 10)
9. How many drinks do you have a day? _____
10. Do you use any illegal drugs? YES _____ NO

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AUTHORIZATION TO VERBALLY DISCLOSE OR PICK UP PERSONAL HEALTH INFORMATION

Patient Name: _____ DOB: _____ MRN: _____

(We) the undersigned patient and/or responsible party hereby authorize NorthRiver Primary Care Associates, it's physicians, agents, employees or contractors to speak with and disclose information to the person or persons indicated below. This does not include or replace the HIPAA Compliant Authorization for Medical Records form needed for requests of medical records by third parties. By signing below, you hereby authorize NRPC to use or disclose information about yourself that is protected by federal law, for the sole purpose and time prescribed below.

☐ Please disclose information only to me. If you check this box, please do not complete the next section.

If you want certain individuals to disclose/pick up information, please complete the next section.

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship

Sensitive Privileged Information: I authorize the release of information relating to AIDS/HIV, psychiatric care and/or psychological assessment, testing and treatment for alcohol and/or drug abuse. ☐ YES ☐ NO

Medicare and Medicare Advantage Patients: If you have enrolled in the Medicare PPO plan called Blue Advantage OR if you have traditional Medicare and are 65 years or older, your plan requires that providers have information on file regarding whether you have an advance directive or not.

☐ No, I do not have an advance directive

☐ YES, I do have an advance directive. The person elected to make those decisions for me is:

Name	Relationship to Patient	Phone Number

_____ _____

Patient or Responsible Party Signature Date

Date: _____ Patient Name: _____ DOB: _____

CHIEF COMPLAINT (Why you are here today): _____

HEALTH MAINTENANCE: Please indicate if you have had any of the following tests. If you cannot remember exactly what year, please approximate)

	Have you had this done?	**If so, when?**	**Results?**
Colonoscopy	Yes or No		
Bone density scan or DEXA	Yes or No		
Mammogram (Females)	Yes or No		
Pap smear (Females)	Yes or No		
PSA Test (Males)	Yes or No		
Pneumonia shot or Pneumovax	Yes or No		
Tetanus shot or Tdap	Yes or No		
Shingles shot	Yes or No		

DIABETICS	**Date**	**Provider**
Eye Exam		
Foot Exam		

PLEASE LIST ANY HOSPITALIZATIONS, SURGERIES OR INJURIES (since last visit):

_____

PLEASE LIST ANY CHANGES IN MEDICATION SINCE LAST VISIT:

_____

PATIENT PORTAL: Our patient portal will allow you access to your medical records. This includes labs, tests, doctor visits, ultrasounds, and much more. If you would like access to the patient portal, please provide information below. After registration, you will receive an email with a link and details on how to access the portal.

First Name: _____ Last Name: _____

Date of Birth: _____ Email address: _____

**I want to receive access to the NorthRiver Primary Care Cerner Patient Portal.

Signature: _____

NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights: You have the right to:

- Get a copy of your paper/electronic medical record
- Correct your paper or electronic medical record
- Get a list of whom we've shared your information
- Tell family and friends about your condition
- Provide mental health care
- File a complaint if you believe your privacy rights have been violated
- Request confidential communication
- Ask us to limit the information we share
- Choose someone to act for you
- Get a copy of this privacy notice
- Provide disaster relief

Our Uses and Disclosures: We may use and share your information as we:

- Run our organization
- Bill for your services
- Help with public health and safety issues
- Address workers' compensation law enforcement, & other government requests
- Treat you
- Do research
- Comply with the law
- Respond to lawsuits and legal actions
- Work with a medical examiner or funeral director
- Respond to organ and tissue donation requests

Your Information

You have the right to:

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

• We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

Choose someone to act for you

• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

• We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

• You can complain if you feel we have violated your rights by contacting us using the information on page 1.

• You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**

• We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

• Share information with your family, close friends, or others involved in your care

• Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

• Marketing purposes
• Sale of your information
• Most sharing of psychotherapy notes

Our Responsibilities

• We are required by law to maintain the privacy and security of your protected health information.
• We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
• We must follow the duties and privacy practices described in this notice and give you a copy of it.
• We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request. Effective Date: 6/15/2016

NORTHRIVER
PRIMARY CARE ASSOCIATES

Clint McEntyre, MD
Cacyce Fowler, CRNP

Scott Kemp, DO
Amy Wyatt, CRNP

PHYSICIANS BOARD-CERTIFIED IN FAMILY MEDICINE

Comprehensive Outpatient Family Medicine, including:

Wellness/Health Maintenance Exams
Outpatient Care for Acute Medical Problems
Internal Medicine
Pediatrics (ages 4 and up)
On-Site X-Ray & EKG
Select In-House Lab Testing
Weekly On-Site Ultrasound
Minor Procedures
Weight Loss Counseling
Telemedicine Services via **Synct**
Botox Injections

We carry a variety of vitamins and health supplements by Pure Encapsulations, as well as a comprehensive list of supplements through our website.

FOR MORE INFORMATION ABOUT OUR SERVICES, ASK OUR STAFF.
WE INVITE YOU TO VISIT OUR WEBSITE AT NorthRiverpca.com

We also offer a provider monitored, evidence-based weight loss program:
Ask our staff or call 205.614.6004 to schedule a consultation.

CMWL®
the center for medical weight loss®