NORTHRIVER
PRIMARY CARE ASSOCIATES
FAMILY MEDICINE, WELLNESS, & SPORTS MEDICINE

4310 Watermelon Road • Northport, AL 35473
Phone: (205)330-5266 • Fax: (205)710-2116

***PLEASE RETURN W/:**
ID/DL & Health Ins Card(s) & Rx Ins Card

Provider Preference: **McEntyre** **Kemp** **Harrison**
Amy Wyatt, CRNP **Jordan Armstrong, CRNP**

We try to respond to all applications within 2 wks | If approved, you must schedule your initial visit w/in 30 days
*****If you No Show or Cancel this Initial Appt, you may not be able to reschedule in the future*****

Patient Name (First, Middle Initial, Last)		Preferred Name:	Today's Date:
Date of Birth	SS#	Sex ☐ M ☐ F	Age
Mailing Address			Apt # | Suite # | Lot #
City	State		Zip
HOME PHONE:		CELL PHONE:	

Have you ever been a patient of NRPCA? ☐ No ☐ Yes | When _____

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

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

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

Preferred Language:
☐ English ☐ Other: _____

Name & Phone # of Interpreter, if used

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

Employment Status:
☐ Full time ☐ Part time ☐ Self-employed ☐ Unemployed ☐ Student ☐ Military ☐ Retired

Occupation	Employer

Emergency Contact | Relationship to Patient | Emergency Contact's Phone #

Are any of your family members current patients of NorthRiver Primary Care? **NO | YES (Please provide name/provider below)**

Patient Name: _____	Patient Name: _____
NRPCA Provider: _____	NRPCA Provider: _____

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Date: _____ Patient Name: _____ DOB: _____

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

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(s) 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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Date: _____ Applicant/Patient Name: _____ DOB: _____

PAST MEDICAL HISTORY

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

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

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

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

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

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

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

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

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

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

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

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

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

Other
- ○ _____
- ○ _____
- ○ _____

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? _____

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Date: _____ Applicant/Patient Name: _____ DOB: _____

Medication	Dose	Frequency	Who prescribed medication?

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

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

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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)

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

_____

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: _____

Email address: _____

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

Signature: _____ Date: _____

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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**

Applicant Signature: _____ **Date:** _____

(Per HIPAA, Applicants/Patients 14 & older MUST sign Release of Information)

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: _____ Phone Number: _____

Relationship to Applicant/Patient: _____

Patient or Responsible Party Signature: _____ Date: _____

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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.

Credit/Debit/3rd Party Cards:

Services performed, that are paid with a credit card, debit card or financing third party (Care Credit) are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow NorthRiver Primary Care Associates to use and disclose my protected to any Credit Card Entity, Bank or Financing Company when they request such information to process an account and assist with payment. I will not challenge such credit, debit or financing card payments once the services are provided. The practice encourages complete care and follow up interaction to address any issues that may arise. I agree that this non-credit card challenge agreement is irrevocable

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/Medical Records:

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. There is a fee as well as a waiting period, of up to 30 days, for all medical records requests. 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 $50.00 for Primary Care appointments that are not cancelled at least 24 hours prior to appointment. There will be a charge of $50.00 for all weight loss appointments with NorthRiver Wellness & Weight Loss that are cancelled on the date of their appointment.

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.

Applicant Signature: _____ Date: _____

(Applicants/Patients 19 & older MUST sign Financial Policies)