Lincoln Internal Medicine, PA
607 S. Generals Blvd Lincolnton, NC 28092.
Ph: 704.736.9188 Fax: 704.736.9667

Welcome to our office. We are committed to providing the best, most comprehensive care possible. All information is confidential and is released only with your consent. Please fill in the blanks below the line.

Patient Name	Today's Date	Date of Birth	Sex	Age
Parent if Patient is a Minor				
Patient's Social Security Number		Driver's License No.		
Home Address	City	State	Zip	
Mailing Address if Different	City	State	Zip	
Home Telephone Number		Work Telephone Number		
Occupation		Employer's Name		
Employer's Address	City	State	Zip	
Spouse Name		Employer		
Other Physician's Name				
Whom May We Thank for Referring You to Our Practice?				
NOTIFY IN CASE OF EMERGENCY				
Name		Relationship		
Address	City	State	Zip	
Home Telephone		Work Telephone		
Nearest Relative (not living with your)				
Home Telephone		Work Telephone		
FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR FEES				
Name		Telephone		
Address	City	State	Zip	
Insurance Company		Claim Address		
Subscriber's Name	Subscriber's Date of Birth	Subscriber's SSN#.		
Insurance ID No.:				
Secondary Insurance		Claim Address		
Subscriber's Name	Subscriber's Date of Birth	Subscriber's SSN#		
Were You Injured on the Job? YES NO		Have you Informed Your Employer? YES NO		
Date of Original Injury:				
Worker's Compensation Carrier Name		Address		

Lincoln Internal Medicine, PA

PATIENT RELEASE OF INFORMATION AND CONSENT

We will attempt to contact you by your preferred contact method regarding your personal medical information. Please be advised, we will attempt to reach you by telephone twice for test results, therefore it is important that you choose more than one method of contact.

Please check your preferred method(s).

Telephone Number: _____

Whom may we speak with?

Name: _____ Phone: _____
Relationship: _____

Name: _____ Phone: _____
Relationship: _____

Name: _____ Phone: _____
Relationship: _____

Voicemail

Phone Number: _____

Fax Number: _____

Email Address: _____

Mail Address: _____

_____

_____

Patient Signature: _____ Date: _____

Lincoln Internal Medicine, PA

MEDICAL HISTORY

NAME DOB AGE DATE

ALLERGIES (medications and reaction): Reaction

SERIOUS INJURY/ILLNESS/OPERATION:

Type Year Name of hospital City and State

Any previous fractures? (circle answer) No Yes

IF YES please Describe:

LIST ALL DOCTORS/PROVIDERS/SPECIALISTS SEEN IN PAST 5 YEARS:

Name Specialty City and State

LIST ALL CURRENT MEDICATIONS INCLUDING OVER-THE-COUNTER MEDICATION/VITAMINS/SUPPLEMENTS/HERBALS

Name DOSE FREQUENCY

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Lincoln Internal Medicine, PA

Medical History

PAST MEDICAL PROBLEMS/ ILLNESSES: Please mark current or past medical problems

- o High blood pressure
- o Heart attack
- o Heart murmur
- o Heart failure
- o Diabetes
- o High cholesterol
- o Atrial fibrillation (irregular heart beat)
- o Stroke
- o Seizure
- o COPD/Emphysema
- o Asthma
- o Pneumonia
- o Asbestos exposure
- o Blood clot/DVT
- o Colon polyps
- o Diverticulosis/Diverticulitis
- o Stomach ulcer
- o Hiatal hernia
- o Hepatitis
- o Alcoholism
- o Pancreatitis
- o Gallstones/Gallbladder attack
- o Anemia
- o Leukemia
- o Lymphoma
- o Cancer
- o Kidney Stone
- o Recurrent Urinary tract infection
- o Enlarged prostate
- o Pelvic Infection
- o Venereal Disease /STD
- o HIV/AIDS
- o Tuberculosis
- o Depression
- o Bipolar Depression
- o Schizophrenia
- o Anxiety
- o Phlebitis
- o Rheumatic Fever
- o Rheumatoid Arthritis
- o Osteoarthritis
- o Osteoporosis
- o Thyroid Trouble
- o Shingles
- o Cataract
- o Glaucoma
- o Breast Cancer
- o Colon Cancer
- o Lung Cancer
- o Ovarian Cancer
- o Uterine cancer
- o Thyroid cancer
- o Prostate cancer
- o Other cancer:

  _____

  _____
- o Other Autoimmune problems:

  _____
- o Date of last Chest X-ray
- o Date of last EKG
- o Date of last TB test
- o Obstetrical:

  # of pregnancies: _____

  # of abortions: _____

  # of miscarriages: _____

  # of living children: _____

Other past medical problems not listed above:

_____

_____

_____

PLEASE FILL IN TO THE BEST OF YOUR KNOWLEDGE AND LEAVE BLANK IF UNKNOWN.

IMMUNIZATIONS	DATE LOCATION
INFLUENZA*	
TETANUS (TD Q10 yrs/TDAP Single dose booster age 19 or older)	
PNEUMOVAX 23*	
PREVNAR 13*	
Hepatitis A	
Hepatitis B * (at risk/diabetics/fatty liver/chronic liver disease/ESRD on dialysis, etc)	
ZOSTER (50 yrs or older)	
VARICELLA	
HPV/GARDASIL (up to age 26 in women, up to age 21 in men)	
MENINGOCOCCAL	

HEALTH MAINTENANCE -DIABETES	DATE	DUE
LAST EYE EXAM		
LAST FOOT EXAM		
URINE MICROALBUMIN		
ACE-I/ARB USE		
LIPID PROFILE (Q5 YRS)		
LDL < 70		
HEMOGLOBIN A1C		
ASPIRIN 81 MG/DAY		
BLOOD PRESSURE		
DIABETES SELF MANAGEMENT TRAINING		

FUNCTIONAL ASSESSMENT – DO YOU NEED ASSISTANCE WITH ANY OF THE FOLLOWING?	YES	NO
BATHING		
DRESSING		
TOILETING		
TRANSFERS/WALKING		
GROOMING (BRUSHING HAIR/TEETH)		
FEEDING		
ADMINISTERING OWN MEDICATION		
GROCERY SHOPPING		
MEAL PREPARATION		
HOUSEKEEPING		
DRIVING AND TRANSPORTATION		
HANDLING OWN FINANCES		
DO YOU NEED HEARING AIDS		
COMPLETING FORMS		

PLEASE FILL IN TO THE BEST OF YOUR KNOWLEDGE AND LEAVE BLANK IF UNKNOWN.

HEALTH MAINTENANCE	DATE LAST COMPLETED	NEXT DUE	NEED
ABDOMINAL AORTIC ANEURYSM SCREEN (+Fam hx or men age 65-75 smoked 100 cigs in lifetime)			
ADVANCED DIRECTIVE / HCPOA/MOST FORM (Living will, surrogate decision maker, FULL/DNR status)			
ALCOHOL MISUSE SCREENING & COUNSELING			
ANNUAL WELLNESS VISIT/ ANNUAL PHYSICAL			
BONE DENSITY/DEXA Q24 MONTHS – primary hyperparathyroidism, x-ray possible osteoporosis/osteopenia/vertebral fx, estrogen deficiency /at risk/ long-term steroid use, certain conditions)			
CARDIOVASCULAR RISK SCREEN – LIPID (Q5YRS)			
CARDIOVASCULAR DISEASE BEHAVIORAL THERAPY Aspirin, BP, diet review)			
CERVICAL & VAGINAL CANCER - PAP (Q24 MONTHS ALL/Q12 MONTHS HIGH RISK)			
COLORECTAL CANCER SCREEN (50 OR OLDER OR 10 YRS PRIOR TO AGE OF DX IF + FAM HX WHICHEVER IS EARLIER) - SCREENING BARIUM ENEMA - SCREENING COLONOSCOPY - FOBT - FLEX SIGMOIDOSCOPY			
DENTAL EXAM			
DEPRESSION SCREEN PHQ2/ PHQ9			
DIABETES SCREENING – HGBA1C (HTN, DYSLIPIDEMIA, BMI>30 OR AGE 65 +OVERWEIGHT/+FAMHX1STDEG/+H/O GESTATIONAL DM)			
DIABETES SELF MANAGEMENT TRAINING			
GLAUCOMA (at risk if DM, + FamHx, AA and age 50 or older, Hispanic and age 65 or older)			
HEPATITIS C SCREEN (blood transfusion prior to 1992, born 1945- 1965, IVDU)			
HIV SCREENING (15-65 yr old or any age if increased risk)			
LUNG CANCER SCREEN (LOW DOSE CT Q1YR- age 55-77, asymptomatic, current smoker or quit in last 15 yrs, at least 30 -pack yrs)			
MAMMOGRAM – SCREENING (age 40 +)			
NUTRITION THERAPY SERVICES (DM, CKD, RENAL TRANSPLANT IN PAST 36 MONTHS)			
OBESITY SCREENING & COUNSELING (BMI >/=30)			
PROSTATE CANCER SCREENING -PSA (MEN AGE 50 –START 1 DAY AFTER 50TH B-DAY)			
STI SCREENING & COUNSELING (GC/CH/RPR/HEPB)			
SHOTS* -FLU, PNEUMONIA, HEP B VACCINES			

Lincoln Internal Medicine, PA

Review of Systems

Constitutional
Recent weight gain
amount _____
Recent weight loss
amount _____
Fatigue
Weakness
Fever

Eyes
Pain
Redness
Loss of vision
Double or blurred vision
Dryness
Feels like something in eye
Itching eyes

Ears-Nose-Mouth-Throat
Ringing in ears
Loss of hearing
Nosebleeds
Loss of smell
Dryness in nose
Runny nose
Sore tongue
Bleeding gums
Sores in mouth
Loss of taste
Dryness of mouth
Frequent sore throats
Hoarseness
Difficulty swallowing

Cardiovascular
Chest Pain
Irregular heart beat
Sudden changes in heart beat
High blood pressure
Heart murmurs

Respiratory
Shortness of breath
Difficulty breathing at night
Swollen legs or feet
Cough
Coughing of blood
Wheezing
H/O asthma

Gastrointestinal
Nausea
Vomiting of blood or coffee ground material
Stomach pain relieved by food or milk
Jaundice
Increasing constipation
Persistent diarrhea
Blood in stools
Black stools
Heartburn

Genitourinary
Difficult urination
Pain or burning on urination
Blood in urine
Cloudy, "smoky" urine
Pus in urine
Discharge from penis/vagina
Getting up at night to pass urine
Vaginal dryness
Rash/ulcers
Sexual difficulties
Prostate trouble

For Women Only:
Age when periods began:_____
Periods regular? Yes No
How many days apart?_____
Date of last period? _____
Date of last pap? _____
Bleeding after menopause? Yes No
Number of pregnancies? _____
Number of miscarriages? _____

Musculoskeletal
Morning stiffness
Lasting how long?
_____Minutes
_____Hours
Joint pain
Muscle weakness
Muscle tenderness
Joint swelling *List joints affected in the last 6 mos.*

_____
_____
_____
_____

Integumentary (skin and/or breast)
Easy bruising
Redness
Rash
Hives
Sun sensitive (sun allergy)
Tightness
Nodules/bumps
Hair loss
Color changes of hands or feet in the cold

Neurological System
Headaches
Dizziness
Fainting
Muscle spasm
Loss of consciousness
Sensitivity or pain of hands and/or feet
Memory loss
Night sweats
Fall in past 6 months
Fall in past 12 months

Psychiatric
Excessive worries
Anxiety
Easily losing temper/Irritable
Depression
Agitation
Difficulty falling asleep
Difficulty staying asleep

Endocrine
Excessive hunger
Excessive urination
Excessive thirst

Hematologic/Lymphatic
Swollen glands
Tender glands
Anemia
Bleeding tendency
Transfusion/when_____

Allergic/Immunologic
Frequent sneezing
Increased susceptibility to infection

Family History

PLEASE MARK THE LETTER NEXT TO THE CONDITION OF APPLICABLE BLOOD RELATIVE AS FOLLOWS:

MOTHER (M) FATHER (F) BROTHER (B) SISTER (S) CHILD (C) MATERNAL GRANDMOTHER (MGM)

PATERNAL GRANDMOTHER (PGM) MATERNAL GRANDFATHER (MGF) PATERNAL GRANDFATHER (PGF)

High Blood Pressure _____
Heart Attack _____
High Cholesterol _____
Diabetes _____
Stroke _____
Cancer -specify type if known: _____
Osteoporosis _____
Tuberculosis _____
Bleeding Disorder _____
Alcoholism _____
Problems with anesthesia during surgery _____
Other/Additional family history :

_____

Mother living? Yes No Cause of death?_____

Father living? Yes No Cause of Death? _____

SOCIAL HISTORY/HABITS (please circle which applies/list as indicated):

Members of household: _____

Marital status: Single/Married/Common Law/Domestic partner / separated/ divorced/ Divorced & Remarried/ Widowed/ Widowed & Remarried

Have you ever used tobacco: YES NO TYPE: CIGARETTES/ E-CIGS/ CHEW/SNUFF DO YOU CURRENTLY USE: YES NO
Age started: _____ Daily smoker/ some day smoker/ second hand exposure Cigarettes # of packs / day _____
Chewing tobacco: cans/ per day _____ DO YOU WANT TO QUIT SMOKING? YES NO Age Quit: _____

Do you drink alcohol?: YES NO TYPE: Beer/liquor/wine Amt per day: Amt per week:

Recreational drug use now or in the past? Type(s) _____IV drug _____ Rx meds_____

Special Diet? YES NO
TYPE?_____

Caffeine intake: # of cups of coffee/ caffeine beverages per day: _____

Do you do self-exam? (breast or testicular) Yes No

Sexual history: # Partners in past year_____MALE/FEMALE/BOTH

Are you at risk for HIV? YES NO
Would you like an HIV test? YES NO

Any prior sexually transmitted infections (herpes, gonorrhea, chlamydia, hepatitis, HIV? YES NO

Education:

Occupation:

Work Hazard Exposure:

DO YOU WEAR A SEATBELT?

How often?

Exercise: _____ Activities & Hobbies: _____ Travel History: _____

LINCOLN INTERNAL MEDICINE, P.A.
LINCOLNTON, N.C.

Health Insurance Portability and Accountability Act (HIPAA) Privacy Policy

1. PURPOSE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

2. APPLICABILITY

a. This notice pertains to individuals receiving covered services. All vocational rehabilitation services for which Federal funding is provided are considered covered services under the health insurance portability and accountability act (HIPAA).
b. This policy applies to all organization's employees, management, contractors, student interns, and volunteers.
c. This policy describes the organization's objectives and policies regarding maintaining the privacy of patient information.

3. PRIVACY NOTICE

a. Please review this information carefully. Lincoln Internal Medicine, P.A. (LIM) understands that medical information about you and your health is personal. Protecting that information is important to us. We are required by law to maintain the privacy of protected health information and to provide you with a notice of our legal duties. We will use and disclose your protected health information only as allowed or required by state and federal law. If it any time you believe your privacy rights have been violated you have the right to file a complaint. Lincoln Internal Medicine's HIPAA Compliance Officer (HCO) is charged with responsibility for all compliance issues, including those with respect to HIPAA. You or your authorized representative may contact:

Kristin N. Raper
Lincoln Internal Medicine
HIPAA Compliance Officer
607 S. Generals Blvd.
Lincolnton, NC 28092
704-736-9188
kraper@lincolnim.net

4. INDIVIDUAL RIGHTS - You have the right to the following:

1) Get a copy of your paper or electronic medical record

a. 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.

b. We will provide a copy or summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

2) Correct your paper or electronic medical record

a. You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.

b. We may deny your request, but we will tell you why in writing within 60 days.

3) Request confidential communication

a. You can ask us to contact you in a specific way (for example: home or office phone) or send mail to a different address.
b. We will not deny reasonable requests.

4) Ask us to limit the information we share

a. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree with your request, and we may deny your request if it would affect your care.
b. If you pay for a service or healthcare item out-of-pocket in full, you can ask us not to share that information for purpose of payment or our operations with your health insurer. We will grant your request unless otherwise required by law.

5) Request a list of those with whom we've shared your information.

a. We will not use or share your health information other than as permitted or without your signed consent.

6) Get a copy of this privacy notice.

a. You can request a paper copy of this notice at any time even if you have agreed to receive this notice electronically.

7) **Choose someone to act for you/ on your behalf**

   a. 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.
   b. We will make sure that person has this authority and can act on your behalf before we take any action.

8) **File a complaint if you believe your privacy rights have been violated.**
   a. You can complain if you feel we have violated your rights.Contact us using the information given.
   b. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by calling 1-877-696-6775 or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/ or sending a letter to the following address:
      i. 200 Independence Avenue S.W.
      Washington D.C. 20201
   c. We will not retaliate against you for filing a complaint.

5. YOUR CHOICES

   a. You have some choices in the way that we use and share information as we do the following:

      1) Tell family and friends about your condition
      2) Provide disaster relief
      3) Include you in a hospital directory
      4) Provide or obtain mental healthcare on your behalf
      5) Market our services
      6) Raise funds

   b. Other Uses and Disclosures: We may disclose your information as we do the following:

      1) Treat you
      2) Run our organization
      3) Bill for your services
      4) Help with public health and safety issues
      5) Do research
      6) Comply with the law
      7) Respond to organ and tissue donation requests
      8) Work with a medical examiner or funeral director
      9) Address worker's compensation, law enforcement, and other government requests
      10) Respond to lawsuits and legal actions

6. **YOUR CHOICES:** For certain health information you can tell us your choice about what share. If you have a clear preference for how we share information in the situations described below, please tell us. *If you are unable 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 information when needed to lessen as serious or imminent threat to health and safety.

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

1) Share information with your family, close friends or others involved in your care.

2) Share information in a disaster relief situation.

3) Include your information in a hospital directory.

In these cases, we never share your information without your written permission.

1) Marketing purposes

2) Sale of your information. We will NEVER sell your information!

3) Most sharing of psychotherapy notes.

4) In the case of fundraising we may contact you for fundraising efforts, but you can tell us not to contact you again.

7. OTHER USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

a. Routine uses: How do we typically use or share your health information? We typically use or share your health information in the following ways:

    1) Treatment, Payment and Operations:
        2) TREATMENT: We can use your health information and share it with other professionals who are treating you. Example: A doctor who is treating you for an injury can ask another doctor about your overall health condition.
        3) RUNNING OUR ORGANIZATION: We can use and share your health information to run out practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.
        4) BILL FOR SERVICES: We can use and share your health information to bill and get payment from health plans or other entities. EXAMPLE: We give information about you to your health insurance plan so it will pay for your services.

b. How else can we use or share your health information: We are allowed or required to share your information in other ways usually in ways that contribute to the public benefits, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gove.ocr/privacy/hipaa/understanding/consumers/indext.him

c. Help with public health and safety issues.
    d. We can share health information about you for certain situations such as:
        e. Prevention of spread of disease
        f. Help with products recalls
        g. Reporting adverse reactions to medications

h. Reporting suspected abuse, neglect, exploitation, or domestic violence.
i. Preventing or reducing a serious threat to anyone's health or safety

j. Conduct Research – We can use or share your information for health research.
k. Comply with the law – We will share information about you if state or federal law requires it, including with Department of Health and Human Services if they want to ensure that we're complying with federal privacy law.
l. Respond to organ and tissue donations – We can share health information about you with organ procurement organizations.
m. Work with a medical examiner or funeral director – We can share health information with a coroner, medical examiner or funeral director when an individual dies.
n. Address worker's compensation, law enforcement, and other government request – we can use of share our health information about you for worker's compensation claims. For law enforcement purposes or with a law enforcement official. With health oversight agencies for activities authorized by law.
o. Respond to lawsuit and legal action – We can share health information about you in response to a court or administrative order, in response to a subpoena.

NARCOTIC CONTRACT

The purpose of this contract is to maintain a safe, controlled treatment plan. I am asking for narcotic pain medication because other treatments and medications I have received have not given enough pain relief. It is unlikely that any medication will completely take away my pain, but for human reasons, narcotic pain medication will be given to me as long as my pain continues, provided that I follow the terms of this contract.

I understand that the possible complications of chronic narcotics therapy include:

- chemical dependence (addiction)
- constipation, which could be severe enough to require medical treatment
- difficulty with urination
- drowsiness
- nausea
- itching
- slowed respiration
- reduced sexual function

If I take more medication that what is prescribed, a dangerous situation could result, such as coma, organ damage, or even death. I understand that if I run out of my medication too soon, or if my medication is stopped suddenly, I could have narcotic withdrawal symptoms which can be very uncomfortable or dangerous. If I become pregnant, there are known or unknown risks to the unborn child which include narcotic addiction and the possibility of the baby experiencing narcotic withdrawal at birth. I am obligated to let my doctors know if I am pregnant, and they will help me find ways of controlling my pain without narcotics.

The terms of this contract include the following:

1. Only one pharmacy will be used for filling narcotic prescriptions

   The pharmacy you have selected is:

   _____

   Phone # : _____

2. If it is found that I received a prescription for narcotic medications from a source other than Lincoln Internal Medicine I will be discharged from Lincoln Internal Medicine and any prescriptions for narcotic medication will be discontinued.
3. It is necessary to call Lincoln Internal Medicine Monday through Friday (9:00 a. m.-5:00 p. m.) to refill medication. It is important to make sure that I have enough medication to get through the weekend or after hours. I will give a 72 hour notice for refill requests.
4. The physician on call or after hours and on weekends will NOT fill my medications. They do not have chart available for review to make decisions regarding medications.
5. I agree and will sign a release to allow Lincoln Internal Medicine doctors to communicate with my referring physician, primary care physician and any pharmacists regarding my use of medications.
6. I will contact and communicate with Lincoln Internal Medicine about narcotic and other pain related medications and side effects. I will NOT contact physicians who do not work at Lincoln Internal Medicine regarding the above concerns. If I have a significant side effect that occurs after hours or during the weekend, it is appropriate to go to the emergency room at the nearest hospital.
7. I agree to take the narcotic medication exactly as instructed by Lincoln Internal Medicine doctors. I am NOT allowed to change dosage amounts or alter the time schedule of taking the medication without

talking to a Lincoln Internal Medicine staff member.

8. I agree that Lincoln Internal Medicine will NOT replace any lost, stolen, or inaccessible narcotic medications or narcotic prescriptions for any reason.
9. I must keep all regular follow-up appointments as recommended by Lincoln Internal Medicine doctors. Failure to comply may cause discontinuation of narcotic prescriptions and possible discharge from Lincoln Internal Medicine.
10. Lincoln Internal Medicine will NOT accept telephone requests for narcotic prescriptions or refills from anyone other than me.
11. All narcotic prescriptions must be picked up by me. If I am too disabled or sick, an exception may be allowed at Lincoln Internal Medicine's discretion.
12. I understand that the benefits of narcotic medications will be evaluated regularly using the following criteria of pain relief:
    - increase in general functions
    - increase in life activities
    - improvement in pain intensity levels
    - absence of unacceptable side effects
    - if appropriate, possible return to work and maintenance of a job
13. I agree to periodic urine screens for other medications and drugs if Lincoln Internal Medicine physicians deem appropriate.
14. I have been given information about the use of narcotic medications and possible risks of side effects including development of tolerance, dependence, addiction, and withdrawal problems due to the medications, and I agree to undergo narcotic administration.
15. I agree to NOT hoard medication or alter the narcotic prescription. These behaviors and other unacceptable behaviors will result in the discontinuation of narcotic prescriptions and possible discharge from Lincoln Internal Medicine.
16. I agree to the following:
    - That I am NOT currently abusing illicit or prescription drugs and that I am not undergoing treatment for substance dependence or abuse.
    - That I have never been involved in the sale, illegal pot session, or transport of ant drugs.
    - *For women only:* That I am not pregnant and that I will inform the physician if I become pregnant.

This form has been fully explained to me, I have read it or have had it read to me, and I understand and agree to the terms of this contract. If any part of this contract as outlined above is broken, I understand that it will result in the immediate discharge from Lincoln Internal Medicine and discontinuation of narcotic prescriptions.

Patient Signature _____ Date _____

Physician/Witness Signature _____ Date _____

Patient Name: _____ Street Address: _____ City, State, Zip: _____ Email Address: _____	Date of Birth: _____ Last 4 numbers of SSN: _____ Telephone: _____
Release Information From: _____ (List applicable Facility(s) and/or Practice(s). _____ _____ (Phone number) (Fax number)	Release Information To: Lincoln Internal Medicine PA (Name of facility, person, or company) 607 S. Generals Blvd. (Relationship) Lincolnton, NC 28092 (Street Address or PO Box, City, State, Zip Code) (Phone number) 704-736-9188(F) 704-736-9667

PURPOSE OF RELEASE (check reason): ☐ Request of individual/personal ☐ Continued patient care ☐ Insurance
☐ Legal purpose including discussions & proceedings ☐ Other _____

Fill in dates of treatment for records to be released:

Treatment dates: From _____ To _____

Office/Clinic Summary: May include most recent office visits, physical exam, consults, diagnostic test results.

Office/Clinic (check all that may apply):	Behavioral Health/Sub. Abuse (check all that may apply):
☐ Office/Clinic Summary ☐ Office Visits ☐ Physical Exam ☐ Laboratory Reports ☐ Radiology Reports ☐ Other _____ ☐ Entire Record (Not including psychotherapy notes)	☐ Hospital Summary ☐ Assessments ☐ Discharge Summary ☐ Physician Orders ☐ Progress Notes ☐ Medications ☐ Lab Reports ☐ Other _____ ☐ Entire Record (Not including psychotherapy notes)
FORMAT: ☐ CD (charges may apply) ☐ Email Address noted above, where permitted ☐ Paper copy (charges may apply) ☐ Other _____	DELIVERY METHOD: ☐ Reg. US Mail ☐ Pick-up ☐ Fax, where permitted ☐ Overnight/Express Mail Service, where permitted ☐ Secure email ☐ Other _____

PATIENT'S RIGHTS – I understand that:

- I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above. Ant cancellation will apply to information not yet released by facility or practice.
- This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases.
- Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.
- Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in health plan, or eligibility for benefits.
- LIM will not share or use my health information without my permission other than by ways listed in LIM's Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at lincolnim.org.
- A fee may be charged for providing the protected health information.
- I have a right to receive a copy of this form upon request.

This permission expires one year after the date of my signature unless another date or event is written here: _____

Signature: _____ Printed Name: _____ Date: _____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form. Note the relationship/authority if signature is not that of the patient (Written Proof May be Requested):
☐ Healthcare Agent/POA ☐ Guardian ☐ Executor/Administrator/Attorney in Fact ☐ Spouse
☐ Parent ☐ Adult Child ☐ Affidavit Next of Kin ☐ Other:

Note: If minor consented for their outpatient treatment for pregnancy, sexually transmitted disease or behavioral/mental health without parental consent, the minor must sign this authorization. When the patient is a minor being treated for substance abuse, the minor must sign this authorization, regardless of who consented for treatment.

Signature of Minor: _____ Printed Name: _____ Date: _____

Authorization given to patient / Date of release: _____ via ☐ Mail ☐ Fax ☐ Other _____
LIM Employee Name & Title: _____ LIM Employee Signature: _____ Date: _____

Update: May 24th, 2019

No Show Policy

Dear Valued Patient,

Lincoln Internal Medicine is committed to providing access and appointment availability to our patients in a manner that fits their needs and availability. In order to maintain appointment availability, we strive to confirm appointments with our patients more than 24 hours in advance.

If you are unable to keep a scheduled appointment, please contact our office as soon as possible to cancel and reschedule this visit. Missed appointments result in reduced access for other patients who may need medical care on an urgent basis. Furthermore, missed appointments may increase costs for all our patients by forcing others to seek costlier options at urgent care clinics or emergency departments.

A "No Show" is defined as an event where a patient misses an appointment without cancelling at least 24 hrs before scheduled time and date. A "Late Cancellation" is when a patient cancel his or her appointment with only 24 hour advance notice.

A patient may be subject to dismissal from the practice on the third no show. Of note, two late cancellations, are equivalent to one no show.

Lincoln Internal Medicine reserves the right to charge a $30.00 no show fee to any patient who fails to keep their regularly scheduled appointment. This fee is assessed to the patient -- it is not reimbursable by your insurance carrier and will be due upon receipt.

Thank you for your understanding – we appreciate you placing your trust in Lincoln Internal Medicine for your healthcare needs.

Sincerely,

Lincoln Internal Medicine

Lincoln Internal Medicine, PA

PATIENT RELEASE OF INFORMATION AND CONSENT

We will attempt to contact you by your preferred contact method regarding your personal medical information. Please be advised, we will attempt to reach you by telephone twice for test results, therefore it is important that you choose more than one method of contact.

Please check your preferred method(s).

Telephone Number: _____

Whom may we speak with?

Name: _____ Phone: _____
Relationship: _____

Name: _____ Phone: _____
Relationship: _____

Name: _____ Phone: _____
Relationship: _____

Voicemail

Phone Number: _____

Fax Number: _____

Email Address: _____

Mail Address: _____

_____

_____

Patient Signature: _____ Date: _____