



# 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?				
<b>NOTIFY IN CASE OF EMERGENCY</b>				
Name		Relationship		
Address	City	State	Zip	
Home Telephone		Work Telephone		
Nearest Relative (not living with your)				
Home Telephone		Work Telephone		
<b>FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR FEES</b>				
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, P.A.  
LINCOLNTON, N C

Patient Notice: Complete Physical Exams and Medicare Wellness Visits

Dear Lincoln Internal Medicine Patient,

Complete Physical Exams (for commercially insured patients) and Medicare Wellness Visits are considered to be an integral part of maintaining long-term health. These visits are dedicated towards creating shared plans with the goal of maintaining health and preventing illness.

- What will happen at my Physical/Wellness Visit?
  - o You may be asked to complete pertinent paperwork that details your past medical history and screens for certain risks (paperwork more so for Medicare Wellness Visits).
  - o Your visit may also include:
    - Check of height, weight, blood Pressure
    - Health risk assessments
    - A review of your health and family history
    - Sharing a list of the health care professionals you see
    - Sharing a list of any medical equipment you use and where you get it
    - A review of all the medicines, supplements, and vitamins currently taken
    - Testing for depression and mental health conditions
    - Discussing risks for certain health conditions and personal health advice
    - Planning a schedule of screening tests/vaccinations over the coming 5-10 years
    - Referrals to any preventive services you may need
    - Screening bloodwork
    - Physical Exam (for commercially insured patients only)
  - o Your visit does NOT include:
    - Illness diagnosis
    - Diagnostic tests: x-rays, ultrasounds, bloodwork (not for screening purposes)
    - Treatments for any conditions you have
    - Physical Exam (not a part of a Medicare Wellness Visit)
- How much does a Complete Physical Exam or Medicare Wellness Visit Cost?
  - o These Complete Physical Exams and Medicare Wellness Visits are fully covered under your insurance. However, if other health problems are evaluated and managed, this may be considered as an additional separate service for which a patient may be charged for – and may include payment of coinsurance, copayments, or a deductible.
- Why Should My Complete Physical Exam or Medicare Wellness Visit be with My Regular Primary Care Provider?
  - o These visits are not required; however, it's a good idea to have them with your regular primary care provider as he/she frequently is the health care provider you have seen the most. He/she can recommend the screenings you need, make sure your medications are right for you, and identify any changes in your health that may occur over time.

Updated 3/21/2019

X Sign

Date



Lincoln Internal Medicine, PA

## HIPAA PRIVACY AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA").

This authorization affects your rights in the privacy of your personal health care information (PHI). Please read it carefully before signing.

By signing this authorization, you acknowledge and agree that Covered Entity may use or disclose any medical information for the purpose(s) of treatment, diagnosis, or insurance approval.

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Covered Entity's HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While Covered Entity has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from Covered Entity at any of its offices or by sending a written request with return address to 308 S. Academy St. Lincoln, NC 28092.

In accordance with your rights under, and subject to certain restrictions imposed by, HIPAA, you may inspect or copy your PHI in the designated record set maintained by Covered Entity for as long as the PHI is maintained in the designated record set.

You have the right to revoke this authorization, in writing, at any time, except to the extent that Covered Entity has taken action in reliance on it. A revocation is effective upon receipt by Covered Entity of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization; (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA; (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of Covered Entity; or (d) six years from the date this authorization was executed.

**By signing this authorization, you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for redisclosure by the recipient and no longer protected under HIPAA.**

Lincoln Internal Medicine will provide you, the patient, with a copy of this signed authorization per your request.

Acknowledged and agreed to by:

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(for Office Use Only)



## 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: \_\_\_\_\_



# MEDICAL HISTORY

NAME	DOB	AGE	DATE
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**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. _____		



# Medical History

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

- High blood pressure
- Heart attack
- Heart murmur
- Heart failure
- Diabetes
- High cholesterol
- Atrial fibrillation (irregular heart beat)
- Stroke
- Seizure
- COPD/Emphysema
- Asthma
- Pneumonia
- Asbestos exposure
- Blood clot/DVT
- Colon polyps
- Diverticulosis/Diverticulitis
- Stomach ulcer
- Hiatal hernia
- Hepatitis
- Alcoholism
- Pancreatitis
- Gallstones/Gallbladder attack

- Anemia
- Leukemia
- Lymphoma
- Cancer
- Kidney Stone
- Recurrent Urinary tract infection
- Enlarged prostate
- Pelvic Infection
- Venereal Disease /STD
- HIV/AIDS
- Tuberculosis
- Depression
- Bipolar Depression
- Schizophrenia
- Anxiety
- Phlebitis
- Rheumatic Fever
- Rheumatoid Arthritis
- Osteoarthritis
- Osteoporosis
- Thyroid Trouble
- Shingles
- Cataract

- Glaucoma
- Breast Cancer
- Colon Cancer
- Lung Cancer
- Ovarian Cancer
- Uterine cancer
- Thyroid cancer
- Prostate cancer
- Other cancer: \_\_\_\_\_

Other Autoimmune problems: \_\_\_\_\_

Date of last Chest X-ray \_\_\_\_\_

Date of last EKG \_\_\_\_\_

Date of last TB test \_\_\_\_\_

Obstetrical:

# of pregnancies: \_\_\_\_\_

# of abortions: \_\_\_\_\_

# of miscarriages: \_\_\_\_\_

# of living children: \_\_\_\_\_

Other past medical problems not listed above:

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





# 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? \_\_\_\_\_ Sexual history: # Partners in past year \_\_\_\_\_ MALE/FEMALE/BOTH Education: \_\_\_\_\_  
Caffeine intake: # of cups of coffee/ caffeine beverages per day: \_\_\_\_\_ Are you at risk for HIV? YES NO Would you like an HIV test? YES NO Occupation: \_\_\_\_\_  
Do you do self-exam? (breast or testicular) Yes No Any prior sexually transmitted infections (herpes, gonorrhea, chlamydia, hepatitis, HIV? YES NO DO YOU WEAR A SEATBELT? How often? \_\_\_\_\_  
Exercise: \_\_\_\_\_ Activities & Hobbies: \_\_\_\_\_ Travel History: \_\_\_\_\_

## 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 than 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 possession, or transport of any 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 or person) \_\_\_\_\_ (Relationship)  
**607 S. Generals Blvd.**  
(Street Address or P.O. Box, City, State, Zip Code)  
**Lincolnton, NC 28092**  
(Phone number) **704-736-9188 (F) 704-736-9167**

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):  
 Office/Clinic Summary  
 Office Visits  
 Physical Exam  
 Laboratory Reports  
 Radiology Reports  
 Other \_\_\_\_\_  
 Entire Record (Not including psychotherapy notes)

Behavioral Health/Sub. Abuse (check all that may apply):  
 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. All 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](http://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: \_\_\_\_\_  
LIM Employee Name & Title: \_\_\_\_\_ via  Mail  Fax  Other  
LIM Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

WELCOME

WELCOME TO LINCOLN INTERNAL MEDICINE, P.A. AS PART OF THE INTAKE PROCESS TO ESTABLISH YOU AS A NEW PATIENT, THE INFORMATION ON THE REVERSE SIDE NEEDS TO BE COMPLETED IN FULL. PLEASE TAKE THE TIME TO COMPLETE ALL THE INFORMATION, INCLUDING THE INSURANCE SECTION.

IN AN EFFORT TO KEEP OUR FEES DOWN THROUGH CONTROLLING ADMINISTRATIVE COSTS, WE HAVE IMPLEMENTED THE FOLLOWING POLICIES:

- 1) ALL PAYMENTS AND CO-PAYMENTS ARE TO BE MADE AT THE TIME OF YOUR VISIT. UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. WE PARTICIPATE IN MOST MAJOR INSURANCE NETWORKS AND WE WILL BILL THE INSURANCE COMPANY IF YOU ARE A PARTICIPANT IN ONE OF THESE PROGRAMS. IF YOU ARE NOT COVERED BY ONE OF THESE PLANS, YOU WILL BE REQUIRED TO PAY AT THE TIME OF SERVICE. UNLESS SPECIAL FINANCIAL ARRANGEMENTS HAVE BEEN MADE WITH OUR BILLING DEPARTMENT PRIOR TO SERVICE. UPON FULL PAYMENT FOR THIS SERVICE, YOU WILL BE GIVEN AN INSURANCE READY RECEIPT IN WHICH YOU MAY FILE WITH YOUR INSURANCE COMPANY FOR REIMBURSEMENT.
- 2) INSURANCE: WHILE WE TRY TO HELP IN ANY WAY POSSIBLE, PLEASE REMEMBER THAT INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. YOU, THEREFORE, ARE ULTIMATELY RESPONSIBLE FOR YOUR MEDICAL BILLS. ANY CHARGES BILLED TO INSURANCE FOR SERVICES PERFORMED AT OUR FACILITY WHICH REMAINS OUTSTANDING FOR MORE THAN 60 DAYS, WILL BECOME THE RESPONSIBILITY OF THE PATIENT OR APPROPRIATE ACCOUNT GUARANTOR (IN CASE OF A DEPENDENT CHILD OR ADULT). AT THIS TIME, IF YOU FEEL YOUR INSURANCE CARRIER HAS INJUSTLY DENIED THESE CHARGES, IT IS YOUR RESPONSIBILITY TO CONTACT YOUR INSURANCE CARRIER TO APPEAL THEIR DECISION.

ACCEPTED METHODS OF PAYMENTS BY THIS OFFICE INCLUDE:

- CASH, MONEY ORDER, CASHIER'S CHECK
- LOCAL, PERSONAL CHECK (WITH PROPER PICTURE I.D.)
- VISA, MASTERCARD, OR DEBIT CARD (WITH PROPER PICTURE I.D.)
- THERE WILL BE A \$25.00 SERVICE CHARGE ELECTRONICALLY DEBITED FROM YOUR BANK ACCOUNT FOR RETURNED CHECKS.
- THERE WILL BE A CHARGE OF \$20.00 FOR APPOINTMENTS NOT CANCELLED WITHIN 24 HOURS (THIS CANNOT BE BILLED TO INSURANCE; WILL BE THE PATIENT'S RESPONSIBILITY).

IF YOU HAVE ANY QUESTIONS CONCERNING THE PAYMENT POLICY, PLEASE ASK PRIOR TO BEING SEEN BY THE PHYSICIAN OR A NURSE.

THANK YOU,

MANAGEMENT

I UNDERSTAND THAT UNPAID MEDICAL FEES MAKE MEDICAL CARE MORE EXPENSIVE FOR ALL PATIENTS. I AGREE THAT IF I FAIL TO PAY MY ACCOUNT IN FULL WITHIN 90 DAYS OF TREATMENT, THAT MY ACCOUNT WILL BE TURNED OVER TO A THIRD PARTY COLLECTOR. I UNDERSTAND AND AGREE THAT IF THIS OCCURS,

I WILL PAY A SEPARATE COLLECTION FEE EQUALING 35% OF THE AMOUNT I OWE.  
I, THE UNDERSIGNED, HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE POLICIES OF LINCOLN INTERNAL MEDICINE, P.A.

\_\_\_\_\_  
SIGNATURE

(SEAL)

\_\_\_\_\_  
DATE



LINCOLN INTERNAL MEDICINE, P.A.  
LINCOLN, 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 at 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/](http://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 a 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 our 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.gov/ocr/privacy/hipaa/understanding/consumers/index.htm](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.htm)
- 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 or 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.

Update: May 24<sup>th</sup>, 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

# Patient Portal



## VIEW DOCUMENTS

View, download your medical documents and securely send documents to other providers.



## VIEW YOUR LAB RESULTS

View the laboratory or diagnostic tests ordered by your physician for you. Also view the results once they are available.



## COMMUNICATE WITH YOUR CLINIC

Send, receive, and document messages to stay in touch with your provider.

Get answers to your medical questions privately from your clinic.



## REQUEST FOR REFILLS

View your current medications and send refill requests to your clinic for any of your medications.



## REQUEST APPOINTMENT

View details of your past as well as future appointments, request to schedule or cancel your appointments.



## FILL ONLINE FORMS

Fill out the forms that are necessary to your scheduled appointment from the comfort of your home prior to your appointment.



## VITAL SIGNS

You can enter your own vital signs.



## VIEW AND PAY YOUR BILL

You can view and pay your bill conveniently at home. You can also add insurance if needed.

## Lincoln Internal Medicine Patient Portal

In order to give you the best service available we want to introduce you to our Patient Portal. All you need is a computer or Smart phone to access this tool. All we need is your email address to send you the link so you can start today to take advantage of the many options that the Portal offers.