FamilyCare

3164 US Hwy 70 Black Mountain, NC 28711
Phone: 828-669-4505 Fax: 828-669-5112

Welcome to Family Care of Black Mountain/Old Fort! Here at Family Care Drew David Schnyder, MD, Morgan Burks, FNP , Anne Parker FNP, and Rhonda Morris, DNP, FNP-BC look forward to providing you the best care possible. We are pleased you have chosen our practice for your healthcare needs. Our providers and staff are devoted to making your healthcare experience with us as pleasant as possible. This Welcome Packet is designed to help you make a smooth transition to becoming a Family Care patient!

At Family Care, you can expect to receive care based on the Patient Centered Medical Home standard of care. This includes care that is carefully designed around evidence-based practice guidelines to assist our patients in reaching their best possible health status; which including providing patients with health education and support needed to effectively manage any chronic conditions. Here at Family Care, you will be a partner in your health care and will be involved in every decision regarding your plan of care.

A key point in Patient Centered Medical Care is choosing a primary care provider, which assures you the most coordinated care possible. You will be asked to designate a primary care provider at your first office visit. Your chosen provider and the health care team that surrounds them will work hard to know you as a person and coordinate all aspects of the care you receive in our office and through other health care providers.

As your primary care practice, Family Care will become the hub of your medical care. We strive to be available to our patients at all times. We encourage you to call our office any time you require medical advice, before seeking care through an Emergency Department or Urgent Care. Calls to our office are returned based on urgency and all calls will be returned within 24 hours of receiving your message. You can reach our office after hours by dialing the office number and speaking with a member of our answering service; our on-call physician will then return your call within **15 minutes.** Any non-emergent requests can also be made through our patient portal (log-in information will be provided to you through e-mail invitation). All portal messages are answered within 24 hours; however we request that you do not use the patient portal for urgent or emergency health questions but instead call the office directly.

We are concerned with your overall health and ask that you share information with us about visits made to providers outside of Family Care to help us better coordinate your care. This packet includes a specialist agreement and we ask that you share this agreement with any specialist you receive care from. Please update us at each visit if you have been to the hospital, Urgent Care, or specialist. If possible, please bring information about this care to your visit or ask you specialist to forward any office notes to us. This helps us coordinate the information into your record and treatment plan. Also, if you have been seen by an Urgent Care or hospital we ask that you call us within 24 hours of your discharge to schedule a follow up appointment with your primary care physician.

If you currently take any medications please bring your medication bottles to your first visit so that your medication and dosage can be documented accurately. Also, please bring a list of any over the counter medications or supplements you are currently using.

Thank you for choosing Family Care of Black Mountain/Old Fort! We look forward to partnering with you to help achieve your best health status possible!

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EMERGENCY CONTACT FORM

Patient Name:_____
First Middle Last

Race: _____ Ethnicity: _____ Language: _____

Sexual Orientation: Heterosexual Bi-Sexual Homosexual Prefer not to answer

Sex: Male Female Identifies as: _____

Date of Birth:_____Social Security #:_____

Phone Number**:** _____**(**Primary**)** _____**(**Secondary**)**

Address**:** _____

City**:** _____ State: _____ Zip code: _____

Email Address**:** _____

WOULD YOU LIKE TO BE ADDED TO OUR PATIENT PORTAL*? Y / N

CONTACT PREFERENCE: TEXT EMAIL PHONE

Emergency Contact Name**:** _____

Emergency Contact Phone Number**:** _____

Relationship to Patient: _____

Signature of Patient or Representative: _____

Date: _____

Patient portal offers you secure online access to your health information from FamilyCare

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GENERAL MEDICAL RELEASE/ AUTHORIZATION FOR USE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ SSN: _____

I authorize _____ to disclose the following information to **Family Care of Black Mountain/ Old Fort:**

- ☐ Complete Medical Records**
- ☐ Laboratory/Pathology Reports only
- ☐ X-ray/Radiology Reports only
- ☐ Progress Notes**
- ☐ Pharmacy/Prescription Records
- ☐ Other (please specify)_____

**NOTE: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted diseases, you are hereby authorizing disclosure of this information

These records are for services provided on the following date(s):_____

Please send above requested records to:

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This information may be used/disclosed for each of the following purposes:

- ☐ For my health care
- ☐ For payment/insurance
- ☐ For Employment Purposes
- ☐ Transfer of Care
- ☐ Other: _____

**This authorization will be valid for 180 days or until notification from the patient (whichever is sooner). This authorization may be revoked at any time by notifying the privacy officer in writing. I do hereby consent and authorize release of copies of my medical records designated above. Any release of information made prior to my revocation shall not constitute a breach of my rights to confidentiality.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Printed Name of Patient or Legal Representative Date

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☐HEALTH HISTORY QUESTIONNAIRE

Name: _____ Date of Birth:_____

SPECIAL COMMUNICATION NEEDS	
Language Preference:	
If you answer "Yes" to any of the questions below, how can we assist you?	
Visual Impairment: ☐ Yes ☐No	**Sensory Impairment: ☐ Yes ☐No**
Speech Impairment: ☐ Yes ☐No	**Cognitive Impairment: ☐ Yes ☐No**
Hearing Impairment: ☐ Yes ☐No	**Other: _____**

PERSONAL HEALTH HISTORY			
Please check any past or current health problems			
	Condition		**Condition**
	Hypertension		Seizures
	High Cholesterol		Headaches
	Diabetes- Type: I or II		Stroke
	Heart Attack or Angina		Prostate problems
	Irregular Heart Rhythm		Breast Cancer
	Congestive Heart Failure		Chronic Urinary Tract Infection
	Asthma		Osteoarthritis
	Emphysema/COPD		Cancer(please list type)
	Pneumonia		Hypothyroidism
	Gastroesophageal Reflux Disease		Hyperthyroidism
	Stomach Ulcer		Bleeding Disorder
	Kidney Problems		Addiction Issues(please specify)
	Liver Disease/ Hepatitis		Anxiety or Depression
	Colon Cancer		Mental Illness (please specify)
	IBS		Other:

PAST SURGICAL HISTORY	
Please check if you have had any of the following	
Procedure	**Year**
Heart Surgery	
Carotid Artery Surgery	
Vascular Surgery/Stent	
Abdominal Aneurysm Repair	
Hysterectomy	
Gallbladder Removal	
Appendix Removal	
Tonsillectomy	
Joint Replacement (Specify Joint):	
Mastectomy ☐Left ☐Right ☐Bilateral	
Lumpectomy	
Prostatectomy	
Hernia Repair	
Pacemaker	
Other:	

MEDICATION			
Please list any medications you are **currently** taking including over the counter, supplements, and herbs			
Medication and Dosage	**Frequency**	**Medication and Dosage**	**Frequency**

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FAMILY HISTORY			
Relationship	**Living?**	**Age**	**Major Medical Problems and/or Cause of Death**
Father			
Mother			
Siblings			
Children			

Specifically have any of your relatives had the following conditions:

Mental Illness: ☐ **Yes** ☐ **No** Relative:	**Chemical Dependency:** ☐ **Yes** ☐ **No** Relative:

Please use this section to describe any concerns you would like to address during your visit today:

_____

_____

_____

_____

HEALTH AND SOCIAL HISTORY	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner	
Education Level: ☐Did not graduate ☐High School Graduate ☐Some College ☐Associates Degree ☐ Bachelor's Degree or Higher	
Occupation: Occupational Concerns: ☐ Stress ☐ Hazardous substances ☐ Heavy Lifting	
How stressful would you rate your current living Situation: 1 2 3 4 5 6 7 8 9 10	
Are there any financial concerns that affect your ability to seek healthcare? ☐ Yes ☐ No If yes, please describe:	
Are there any religious or culture factors that you would like us to take into account when planning your health care? ☐ Yes ☐ No If yes, please describe:	
Tobacco Use: ☐ No Tobacco Use ☐ Former Tobacco User- Quit: _____ ☐ Current Tobacco User (specify type below) If current tobacco user, please specify type of tobacco and frequency: _____	
Alcohol Intake: ☐ No ☐Yes If yes, how many drinks per month:_____	
Illicit Drug Use: ☐ None ☐ Past Drug Use ☐ Current Drug Use Please describe previous or current drug use:	
Exposure to Second Hand Smoke: ☐ No ☐ Yes	Wear a Seatbelt: ☐ No ☐ Yes
Eat a diet high in fruits and vegetables: ☐ No ☐ Yes	See a dentist at least once a year: ☐ No ☐ Yes
Get 30 minutes of exercise 5 times a week: ☐ No ☐ Yes	Wear Sunscreen: ☐ No ☐ Yes

ALLERGIES			
Allergen	**Reaction**	**Allergen**	**Reaction**

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HEALTH MAINTENANCE			
Please indicate if you have had these prevent services and include year			
Immunizations	**Year**	**Testing**	**Year**
Tetanus/DTaP Vaccine ☐Yes ☐No		**Pap Smear ☐ Yes ☐ No**	
Pneumonia Vaccine ***Prevnar 13 ☐ Yes ☐ No** ***Pneumovax 23 ☐ Yes ☐ No**		**Mammogram ☐ Yes ☐ No**	
Influenza Vaccine ☐ Yes ☐ No		**Bone Density Study ☐ Yes ☐ No**	
Shingles Vaccine ☐ Yes ☐ No		**Colonoscopy ☐ Yes ☐ No**	
		Prostate Exam ☐ Yes ☐ No	

SPECIALISTS					
To help with coordination of care, please provide the name and last visit date below of any medical providers you see outside of FamilyCare					
Specialist	**Provider Name**	**Last Visit**	**Specialist**	**Provider Name**	**Last Visit**
Eye Doctor			Nephrologist		
Cardiologist			Psychiatrist		
Oncologist			Allergist		
Urologist			Vascular		
Gynecologist			Pulmonology		
Gastroenterologist			Other:		
Endocrinologist					

URINARY AND BOWEL CONCERNS	
Do you experience any urinary leakage/issues: ☐ No ☐ Yes If yes, please give brief description of issues:	Do you experience bowel issues (i.e. leakage, diarrhea, constipation): ☐ No ☐ Yes If yes please give a brief discription of issues:

FALL RISK SCREENING
Have you fallen more than once the past twelve months: ☐ No ☐ Yes If yes, how many times have you fallen?____
Were you injured as a result of fall(s)? ☐ No ☐ Yes If yes, please give brief description of injuries below

MOOD SCREENING
A person's mood can have a strong influence on their health and overall well- being. Over the past month, how often have you been bothered by the following issues.
Little interest or pleasure in doing things: ☐ Not at all ☐ Several days ☐ More than two weeks ☐ Every Day
Feeling down, depressed, or hopeless: ☐ Not at all ☐ Several days ☐ More than two weeks ☐ Every Day

ADVANCED DIRECTIVES	
Do you currently have or want information on any of the following	
Living Will:	☐ Have ☐ Declined ☐ Request more information
Durable Power of Attorney:	☐ Have ☐ Declined ☐ Request more information
DNR Order:	☐ Have ☐ Declined ☐ Request more information

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FUNCTIONAL ASSESSMENT	
How often do you need assistance with the following:	
Bathing, dressing, and grooming	☐ **Not at all** ☐ **Sometimes** ☐ **Most of the time**
Daily Activities (cooking, cleaning, other household tasks)	☐ **Not at all** ☐ **Sometimes** ☐ **Most of the time**
Walking or Driving	☐ **Not at all** ☐ **Sometimes** ☐ **Most of the time**
Communicating needs and feelings	☐ **Not at all** ☐ **Sometimes** ☐ **Most of the time**
Understanding directions	☐ **Not at all** ☐ **Sometimes** ☐ **Most of the time**
Keeping appointments, taking medications, and performing other medical treatments	☐ **Not at all** ☐ **Sometimes** ☐ **Most of the time**

HEALTH LITERACY QUESTIONNAIRE	
Many times in healthcare, staff and providers use words that are unfamiliar to the general public. Please rate each statement from 1 to 10; 1 being strongly disagree and 10 being strongly agree	
I feel that I have a thorough understanding of the instructions my doctors and nurses give me about my health	1 2 3 4 5 6 7 8 9 10
I feel that I remember the instructions when I get home	1 2 3 4 5 6 7 8 9 10
I feel that I have a strong understanding of medical language	1 2 3 4 5 6 7 8 9 10

CONSENT TO TREAT:

I hereby consent to evaluation, testing, and treatment as directed by my Raleigh Durham Medical Group physician or his or her designee.

Patient Signature: _____ Date: _____

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RALEIGH DURHAM MEDICAL GROUP
PATIENT DISCLOSURES AND CONSENTS

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to Raleigh Durham Medical Group or the physician individually for services rendered to my dependents or me by the physician or a provider under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Raleigh Durham Medical Group is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's benefits be mad directly to Raleigh Durham Medical Group or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I have received and read a copy of Raleigh Durham Medical Group's Patient Information Privacy Policy. I hereby authorize Raleigh Durham Medical Group or the physician individually to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL, OR E-MAIL:

I certify that I understand the privacy risks of the mall, phone calls, and e-mail. I hereby authorize Raleigh Durham Medical Group representative or my physician to mall, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Raleigh Durham Medical Group to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:

I understand that I may receive a separate bill if my medical care includes labs, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREAT:

I hereby consent to evaluation, testing, and treatment as directed by my Raleigh Durham Medical Group physician or his/her designee.

Patient Signature: _____ **Date**: _____

Guarantor Signature:_____ **Date**: _____
(If different from patient)

Guarantor Name (Please print): _____

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☐MEDICAL INFORMATION RELEASE FORM (HIPAA)

Name: _____ Date of Birth: _____

Release of Information

- ☐ Family Care is authorized to release protected information about the above named patient to the parties named below. The purpose is to inform the patient/ approved parties in keeping with the patient's instructions and right to privacy.
  - ☐ Spouse: _____
  - ☐ Children: _____
  - ☐ Other: _____
- ☐ Information is not to be released to anyone except the patient

This ***Release of Information* will remain in effect until terminated in writing by patient**

Messages

Please indicate the best method to contact you and provide phone number in space provided:

- ☐ My house: _____
- ☐ My cellphone: _____
- ☐ My work: _____

If unable to reach me please:

- ☐ You may leave a detailed message
- ☐ Please leave a message asking me to return your call

The best time to reach me is (day)_____ between (time)_____

Patient Signature: _____ Date: _____

Signature of Legal Representative: _____

Printed Name of Legal Representative: _____

SDOH SCREENING

NAME:_____ DOB:_____

1.) Is the member worried or concerned that in the next two months they may not have stable housing that they own, rent, or stay in?

- No concerns
- Unwilling to answer
- Yes, concerns related to
- Other problems related to Housing.

2.) In the past 12 months has a member or any family members been unable to pay their utilities, clothing, medicine or obtain healthcare services?

- No concerns
- Unwilling to answer
- Yes, concerns related to
- Other problems related to Money and Resources

3.) Does the member have a transportation barrier to attend appointments and necessary activities?

- No concerns
- Unwilling to answer
- Yes, concerns related to
- Other problems related to Transportation.

4.) Does the member need support with day-to-day activities such as preparing meals, shopping, bathing, managing finances etc. and or feel isolated?

- No concerns
- Unwilling to answer
- Yes, concerns related to
- Other problems related to Social Connectiveness

NAME: **DOB:**

Depression Screening

Over the past two weeks how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling/staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself, or that you are a failure, or have let yourself or your family down				
Trouble concentrating on daily tasks				
Moving or speaking so slowly that other people could have noticed, or being so fidgety or restless that people could have noticed				
Thoughts that you would be better off dead or of hurting yourself in some way				

Anxiety Screening

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious, or on edge				
Not being able to stop or control worrying				
Worrying too much about different things				
Trouble relaxing				
Being so restless it is hard to sit still				
Becoming easily annoyed or irritable				
Feeling afraid as if something awful might happen				

NAME: **DOB:**

If you checked yes to any of these problems, how difficult have they made it for you to work, take care of things at home or get along with other people?

Not difficult at all Somewhat difficult Very difficult Extremely difficult