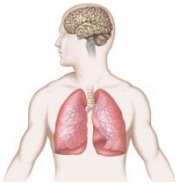


Eastern Medical Associates, P.A.

Pulmonary, Neurological and General Adult Medical Care

Welcome to Our Practice!

Please take time to answer the questions in this new patient packet carefully and completely and sign your name in all appropriated places. This is the most important thing you can do to help us take care of you.
Please complete these forms in blue or black ink and either mail them back to 2609 Medical Office Place Goldsboro, NC 27534 or bring them with you the day of your appointment.

Following this letter, we have also included information about our practice to help you understand our privacy, medication and payment policies. If you have any questions about the forms or policies of the office, please feel free to contact us.

If you cannot keep an appointment, please remember to call our office at least 24 hours in advance so that time can be made available to other patients. Remember to bring all medications, insurance cards, valid photo ID and co-pay or deductible payments to each visit.

Thank you for choosing our practice for your care. We look forward to taking care of you.

ALL FORMS MUST BE SIGNED BY THE PATIENT UNLESS THERE IS A VALID MEDICAL REASON PREVENTING IT. POA AND/OR GUARDIAN PAPERWORK MUST BE PROVIDED TO THE OFFICE.

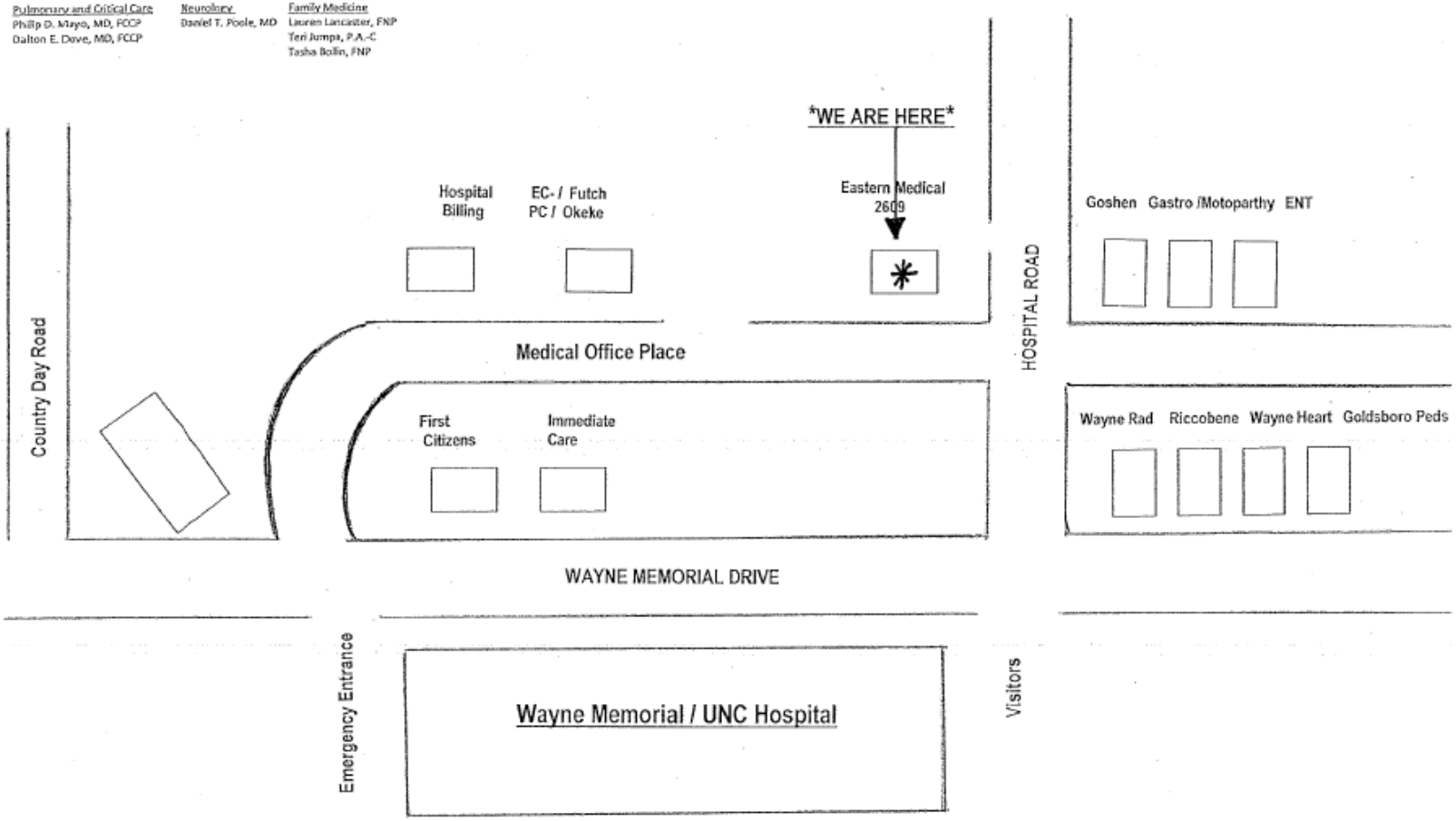
**Please continue to next page...

EASTERN MEDICAL ASSOCIATES, PA
2609 Medical Office Place Goldsboro, NC 27534
Phone: (919)-734-1779 Fax: (919)-734-7570

Pulmonary and Critical Care
Philip D. Mayo, MD, FCCP
Dalton E. Dove, MD, FCCP

Neurology
Daniel T. Poole, MD

Family Medicine
Lauren Lancaster, FNP
Teri Jumpa, P.A.-C
Tasha Bollin, FNP



Eastern Medical Associates New Patient Information

(Failure to fill out application **completely** will delay processing your appointment.)

Name (first, middle and last):
Date of Birth: **Social Security Number:**
Mailing Address:
City: State: Zip Code:
Primary Phone **(THIS number will be used for ALL contact from us including appointment reminder calls):**
Secondary Phone **(for emergencies only)**:
E-mail: **(for Patient Portal access only)**
Race:
Ethnicity: (please circle) Hispanic / Non-Hispanic / All Others
Language: (please circle) English / Spanish / Other
Marital Status: (please circle) Single/ Married/ Seperated/ Divorced/ Widowed
Current Primary Physician: ***Previous*** Primary Physician **(If recently changed):**
Referring Physician **(List only if seeing one of our Specialists):**
Name of Pharmacy:
Location of Pharmacy:
Employer Name, Address & Phone:

EMERGENCY CONTACT:

Emergency Contact's Name:
Relationship To Patient:
Contact Phone:

**Please continue to next page...

INSURANCE INFORMATION:

Do you have insurance? (please circle) **Yes** – I have insurance

or

No – I am self-pay

PRIMARY INSURANCE:

Subscriber Name:
Subscriber Date Of Birth:
Relationship To Patient:
Insurance Name:
Policy Number:
Group Number:

SECONDARY INSURANCE: (If applicable)

Subscriber Name:
Subscriber Date Of Birth:
Relationship To Patient:
Insurance Name:
Policy Number:
Group Number:

TERTIARY INSURANCE: (If applicable)

Subscriber Name:
Subscriber Date Of Birth:
Relationship To Patient:
Insurance Name:
Policy Number:
Group Number:

I affirm the information I have given is correct to the best of my knowledge. I assign Eastern Medical Associates, P.A. all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize EMA to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions whether manual or electronic. I acknowledge receipt of the notice of privacy practices of EMA. I understand that the notice of privacy practices contains information on uses and disclosures of any personal health information and I have been given the opportunity to review the notice. I understand that the terms of the notice may change and that I will be given a revised notice if changes occur. I understand that I may request restrictions on the uses and disclosures of information for the purpose of treatment, payment or health care operations. I also understand that EMA is not required to agree to such requests, but if it does not agree, those restrictions are binding on Eastern Medical Associates, P.A.

Patient or Responsible Party Signature_____Date_____

****Please continue to next page...**

Health/Personal History

(Failure to fill this out **completely** will delay in processing your appointment)

Patient Name:	**Date Of Birth:**
Do you have any children at home? (please circle) YES / NO If yes, how many?_____	
How many adults live in your home? _____	
Do you use caffeine? (please circle) YES / NO	
Have you ever abused prescription medications? (please circle) YES / NO	
If yes, what medication did you abuse?_____	
Is there anything else we should know about your medical history?	

WOMEN ONLY

Do you suspect you are pregnant?
Are you currently nursing?

TOBACCO USE: (please check)

_ Current every day smoker? How many per day? ____ For how many years? ___
_Current some days smoker? How many per week? ____ For how many years? ___
_ Former Smoker How many years did you use tobacco products?___
What year did you quit?____
_ Never a smoker
_ Only uses smokeless tobacco

ALCOHOL USE: (please check)

_ Never drinks _ Past drinker only
_Occasional drinker _ Current everyday drinker How many drinks per day? _

ILLEGAL DRUG USE /HISTORY: (please check)

_ Have never used illegal drugs
_ Currently uses illegal drugs What drugs are you using?_____
_ Past Only What drugs did you use? _____ How many years?_____

I affirm that the above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my medical provider or any member of his/her staff responsible for errors or omissions that I may have made in the completion of this form. In addition, by signing below, I consent to Eastern Medical Associates downloading any available prescription history in order to better assist in my personal care. I also authorize Eastern Medical Associates to order the performance of blood tests to determine the presence or absence of antibodies of HIV and HBV in my blood if a healthcare provider is directly exposed to my blood or bodily fluids in a manner which may transmit disease.

****Please continue to next page...**

Patient Medical History

(Failure to fill out application **completely** will delay processing your appointment.)

MEDICAL PROBLEMS: Please check all that apply:

_ Heart Disease
_ High Blood Pressure
_ Pacemaker
_ Artificial Heart Valves
_ ICD Defibrillator
_ Arthritis
_Convulsions
_ Diabetes
_ Blood Clots
_ Stroke
_ Radiation Treatment
_ Cancer
_ Gout
_ Bleeding Tendency
_ Mental Illness
_ Venereal Disease
_ Hepatitis
_ HIV/AIDS
_ Chemical Dependency
_ Acute Infections
_ Hereditary Defects

Food Allergies & Reactions:
Drug Allergies & Reactions:
Environmental Allergies:
Do you take allergy injections? (please circle) YES / NO

HOSPITILAZATIONS/SERIOUS INJURY/SURGICAL HISTORY

Procedure:	Year:	Location:

FAMILY MEDICAL HISTORY:

Family Member:	Age:	Diseases:	If Deceased, Cause of Death:
Father			
Mother			
Siblings			
Spouse			
Children			

****Please continue to next page...**

PATIENT MEDICAL HISTORY CONTINUED…….

Circle Yes for any that apply:

Good general health	Yes
Recent weight change	Yes
Fever	Yes
Fatigue	Yes
Headaches	Yes

EYES

Eye disease/Injury	Yes
Wear Glasses/contacts	Yes
Blurred/Double Vision	Yes
Glaucoma	Yes

ENT

Hearing loss	Yes
Ringing in ears	Yes
Earaches/Drainage	Yes
Sinus problems	Yes
Nose bleeds	Yes
Mouth sores	Yes
Bleeding Gums	Yes
Bad Breath or bad taste	Yes
Sore throat/Voice changes	Yes
Swollen glands in neck	Yes

CARDIOVASCULAR Yes

Heart trouble	Yes
Chest Pains	Yes
Sudden heart beat changes	Yes
Swelling of feet, ankles/hands	Yes

RESPIRATORY Yes

Frequent coughing	Yes
Spitting up blood	Yes
Shortness of breath	Yes
Asthma or wheezing	Yes

GASTROINTESTINAL Yes

Loss of appetite	Yes
Change in bowel movements	Yes
Nausea or vomiting	Yes
Frequent diarrhea	Yes
Painful bowel movements	Yes
Constipation	Yes
Blood in stool	Yes
Stomach	Yes

GENITOURINARY

Frequent urination	Yes
Burning/Painful urination	Yes
Blood in urine	Yes
Change of force when urinating	Yes
Incontinence or draggling	Yes
Kidney stones	Yes
Male- testicle pain	Yes
Female – pain w/periods	Yes
Female – irregular periods	Yes
Female - vaginal discharge	Yes

Female - # pregnancies_____ # miscarriages_____

Date of last pap ____ ____ Results of last pap - Normal Abnormal

MUSCULOSKELETAL

Joint pain	Yes
Joint stiffness or swelling	Yes
Weakness of muscles/joints	Yes
Muscle pain or cramps	Yes
Back pain	Yes
Cold Extremities	Yes
Difficulty walking	Yes

SKIN

Rash/Itching	Yes
Change in Skin Color	Yes
Varicose veins	Yes
Breast pain	Yes
Breast lump	Yes
Breast discharge	Yes

NEUROLOGICAL

Frequent/Recurring headaches	Yes
Light headed or dizzy	Yes
Convulsions or seizures	Yes
Numbness or tingling	Yes
Tremors	Yes
Paralysis	Yes
Stroke	Yes

PSYCHIATRIC

Memory loss/Confusion	Yes
Nervousness	Yes
Depression	Yes
Sleep problems	Yes

ENDOCRINE

Glandular/Hormone Problems	Yes
Thyroid disease	Yes
Excessive thirst or urination	Yes
Heat or Cold Intolerance	Yes
Dry skin	Yes

ENDOCRINE

Glandular/hormone problems	Yes
Thyroid disease	Yes
Excessive thirst or urination	Yes
Heat or cold intolerance	Yes
Dry Skin	Yes

HEMATOLOGICAL/LYMPHATIC

Slow to heal after cuts	Yes
Easily bruise	Yes
Anemia	Yes
Phlebitis	Yes

**Please continue to next page…

MEDICATION INFORMATION

Patient Name:	**Date of Birth:**

**List all current prescriptions, vitamins, supplements or over the counter medications. Include dosage and how many times taken per day. If you need more room to include additional medications, please attach a list with the information below.

BRING ALL MEDICATIONS WITH YOU TO EACH APPOINTMENT!

Medication:	Dosage:	How Often:
Medication:	Dosage:	How Often:
Medication:	Dosage:	How Often:
Medication:	Dosage:	How Often:
Medication:	Dosage:	How Often:
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Medication:	Dosage:	How Often:

Are you prescribed any **PAIN medication**?
If yes, name of medication:
If yes, who has been prescribing this medication for you?

WOMEN ONLY

Do you suspect you are pregnant?
Are you currently nursing?

**Please continue to next page...

MEDICATION AND REFILL POLICY

WE REQUIRE THAT YOU BRING ALL OF YOUR CURRENT MEDICATION BOTTLES OR A DETAILED LIST TO EACH AND EVERY APPOINTMENT. THIS IS FOR YOUR SAFETY.

IMPORTANT: In order to keep thorough documentation and a consistent plan in place, you need to **call your pharmacy to fax your refill requests to our office**. This will ensure accuracy of prescription drug names, current dosing and timing of refills**. THIS IS THE FASTEST WAY TO GET YOUR MEDICATION**. If there is a **problem** with your refill, call our refill line at 919-734-1779 **Option 1****

- Be sure to leave **all** requested information in your message.
- **DO NOT** call in a refill at Eastern Medical if you have already requested it from your pharmacy.
- **DO NOT** leave refill requests on **ANY VOICEMAIL** other than the one designated on **OPTION 1**.
- **DO NOT** request an individual nurse's line or your doctor's nurse's line to request refills. The nurses are very busy all day long and this will slow down the response times and the refill process. If you have a question about a prescription, contact your pharmacist or leave a message on the refill line at **OPTION 1**.

You should **monitor your supply on hand** and always call ahead to **allow the pharmacy and our office at least 48 hours to process your request**. Duplicate calls will slow down our response time.

Medications including antibiotics for acute problems are not to be called in without the patient being seen first. To ensure your safety, quality of care, proper diagnosis and appropriate antibiotic usage, a provider must evaluate you.

If you are taking any controlled drugs (such as narcotic pain medication), you will be asked to sign a *Controlled Substance Agreement/Contract* to ensure proper prescribing and administration of these medications.

- For your safety, only your primary care provider will refill controlled drugs.
- Controlled medications will not be refilled after normal office hours.
- There are regulations on controlled medications that this office must follow.
- You are responsible for keeping these medications in a safe and secure place at all times.

You need to schedule and keep routine appointments with your primary care provider if you are on any health maintenance medications for conditions such as high blood pressure, diabetes etc. Your provider will make sure that you do not run out of your required medications if they are seeing you on a routine basis.

Thank you for your cooperation and working in partnership with your provider and your pharmacist.

Patient Signature _____ Date_____

Relationship to Patient _____

****Please continue to next page...**

Eastern Medical Associates Payment Policy

Payment is due at the time of service for any amount not usually covered by your insurance plan, **including co-payments and deductibles.**

If you are unable to pay in full, other arrangements **must** be made **prior** to the day of your appointment.

Monthly statements will be sent for any balance on your account for $3.00 or more. Balances for less than $3.00 may be collected at the next visit. Payment is due upon receipt of statement. If you are unable to pay in full, arrangements must be made with our Billing and Insurance Department. We encourage patients to contact that department at extension #219 should they have any questions or need arrangements.

Past Due Policy

If your account is past due, payment arrangements must be made before your next appointment. We **DO** use a collection agency to collect our past due accounts.

If no payment is received within 90 days and no arrangements have been made, an attempt will be made to contact you by phone and by letter. If this is unsuccessful and neither payment nor arrangements are made, the account will be placed for collection and no appointments or medications will be given until payment or arrangements have been made.

Returned Check Policy

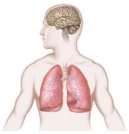
Returned checks are subject to a $25.00 service charge form this office and will be handled the same as above.

Patient Signature_____ Date_____

Or

Signature and Relationship_____ Date_____
(only if patient is unable to sign)

****Please continue to next page...**



E.M.A. Pulmonary, Neurological and general adult medical care

Due to the high volume of patients needing to be seen by the Specialists and Primary Care Providers at Eastern Medical Associates and the importance of attending all scheduled visits, our office has established the following guidelines regarding canceled, no show and late appointments:

Late Policy

1. Patients who arrive more than 5 minutes after their scheduled appointment time will be considered late.
2. Late appointments will be rescheduled for another date/time. Depending on the discretion of the provider, the volume of patients scheduled and the time of arrival, the provider may opt to "work" your appointment into the schedule.

Cancel/No Show Policy

1. Patients/guarantors must notify Eastern Medical Associates at 919-734-1779 within 24 hours of their scheduled appointment if they need to cancel and appointment. This allows the office to schedule another patient in that time slot.
2. Patients/guarantors who do not call within 24 hours of their scheduled appointment and/or fail to show up for a scheduled appointment will be considered a "no-show".
3. Patients/guarantors with 3 or more "no-show" appointments within a 12 month period will receive a letter in the mail, informing of their discharge from the office due to excessive "no-shows".
4. Patients/guarantors will be charged $45.00 for each no show appointment. You will receive a statement in the mail. This fee will be due prior to you being seen in our clinic by any provider.
5. Patients/guarantors, it is YOUR responsibility to make sure contact information, including telephone number, address and emergency contact person, stay current and up to date at our office. If you have had any change at all please confirm your information is correct on your medical record.

Patient Portal

This is not mandatory for our patients, but is an optional service that we offer.
If you are interested in participating in the portal, please ask one of our staff members to assist with information about getting started.
You will be given a token number to use when enrolling. Please go to www.nextmd.com to enter your one time use token number once you have received it.
Should you have any issues enrolling or have further questions please call our office at 919-734-1779.

Patient Signature_____ Date_____

Or

Signature and Relationship_____ Date_____
(only if patient is unable to sign)

****Please continue to next page...**

Authorization to Release Information

- I authorize the medical and administrative staff of Eastern Medical Associates to release Any and All medical information including lab results, appointment information, medical records, insurance information, prescriptions and prescription information to the below list of people. I understand that I can change this list of people at any time by completing a new form and submitting it to EMA for my records.
- On the lines below, list the full names of **ANYONE you authorize** Eastern Medical Associates to recognize as **having your permission** to speak or be represent on your behalf. EMA will not release private medical information, forms or any other correspondence without your consent.

_____ Spouse

_____ Child

_____ Parent

_____ Other

**** This authorization is permanent unless updated with new signature and date. ****

In general, the HIPPA privacy rule gives individuals the right to request a restriction on the uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Uses and disclosures for TPO (treatment, payment and health care operations) may be permitted without prior consent in an emergency.

Patient Signature_____ Date_____

Or

Signature and Relationship_____ Date_____
(only if patient is unable to sign)