



1000 Darrington Dr. Suite 104 • Cary, NC 27513 • Phone (919) 380-1849 • Fax (919) 380-1851

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**Dear Patient,**

On behalf of our physicians and staff, we would like to welcome you to our practice.

Our practice specializes in providing excellent health care for patients of all ages. We work closely with each patient to provide care for chronic and acute medical conditions while emphasizing preventive health screenings and education. Our practice provides comprehensive health care using advanced medical technology and offers a wide range of convenient on-site services to our patients. In addition, we have access to a wide variety of specialists and diagnostic testing facilities should your care necessitate a referral of any kind.

I've included information about our practice and physicians should you wish to schedule an appointment. Please feel free to contact our office at (919) 380-1849 with any questions you may have.

We look forward to meeting you soon.

Sincerely,

Wake Family Medicine.

### **To Schedule/Cancel an Appointment**

Appointments can be scheduled/ cancelled by calling the office

*Note: Please call the office in advance if there is a change or cancellation. A cancellation fee will be applied if you are unable to contact us within 24 hours prior to your appointment.*

Listed below are a few of our most common referral centers and a few services they are referred for:

*For colonoscopy, GERD, and reflux*  
Center for Digestive Diseases  
1120 Southeast Cary Parkway  
Suite 204

*For ultrasound and MRI*  
Wake Radiology  
300 Ashville Ave, Suite 100  
Cary, NC 27518

*For headache*  
Raleigh Neurology  
1540 Sunday Drive  
Raleigh, NC 27607

*For diabetes and thyroid*  
Carolina Endocrinology  
3840 Ed Drive, Suite 111  
Raleigh, NC 27612

### **Clinical Advice**

During office hours, contact the office and follow the prompts to speak with the clinical staff. You can also send a message through [portal.athenahealth.com](http://portal.athenahealth.com) once you have been set up during registration process.

After hours, contact the answering service at 919-696-1346-who will connect you with the on-call provider.

### **Extended Hours**

Our regular business hours are: Monday-Friday, 8:00 AM -5:00 PM with telephone hours from 7:45am – 4:30pm. Additionally, on Saturday from 8:30 AM-12:30 PM, we offer extended hours for our established patients for acute visits only (i.e. cold, cough, upper respiratory infection, etc.). To be seen during these hours, you may call our office that morning for an appointment.

### **Transferring Records**

Our practice functions most effectively as a medical home if we have a complete medical history for our patients and information about care obtained outside the practice. To transfer your records to our practice, please fill out the Release of Information (ROI) form (enclosed). You may print additional forms from our website, [www.wakefamilymedicine.com](http://www.wakefamilymedicine.com)

For additional assistance, please call the office and follow the prompts for medical records.

### **Patient Centered Medical Home**

Our practice functions as a Patient Centered Medical Home. A Patient Centered Medical Home (PCMH) is a team-based approach to health care. The team is made of health care providers, support staff, and most importantly—**YOU**. As your medical home, we will take care of you when you are sick and when you are well. We will help you set and achieve health-related goals. We will work with you, additional health care providers, and other resources in the community to coordinate your care.

To be an active participant in your care, you should:

- See your provider at regularly scheduled intervals or as needed.
- Maintain and update your medical history with your provider.
- Tell your provider about any other health care professionals who care for you.
- Remain engaged in your care plan and ask questions about your treatment plans. Give feedback about the care you are receiving.
- Feel empowered to take care of your health and collaborate with your provider to make decisions about your treatment.

### **FAQs**

To help you get acclimated with our practice we have compiled the answers to some of the most common questions we get from our patients.

#### *What is a Family Physician?*

A family physician is a doctor who is devoted to comprehensive health care for people of all ages. Family medicine's cornerstone is an ongoing, personal patient-physician relationship focusing on integrated care.

#### *What ages do you treat?*

We treat patients of all ages ranging from newborn to geriatric patients.

#### *What if I need to see the doctor right away?*

For life-threatening emergencies, please call 911 or go to the nearest Hospital Emergency Room for treatment. For other emergent situations, call the office at (919) 380-1849 and we will do our best to address your need. You may also utilize one of the UNC Rex Express Cares or UNC Urgent Care in the triangle area.

#### *What is a family nurse practitioner?*

A family nurse practitioner is an advanced practice registered nurse that blends clinical expertise in diagnosing and treating health conditions with an added emphasis on disease prevention and health management. Much like a family physician, Family Nurse Practitioners work with patients throughout their lives, diagnosing illness, conducting exams, and prescribing medication.

*What information do I need to bring to my appointment?*

If you are a new patient, please bring your insurance card, driver's license (or other picture ID), a list of your current medications and the completed registration forms found in the form section of our website.

If you are an established patient, please bring your insurance card, a list of other health care professionals that you have seen since your last visit, details of any hospitalizations or ER visits, any medications that you are taking (including prescribed, over-the-counter, and herbal remedies), and any questions that you may have.

*What if I don't have insurance?*

We are committed to serving all patients regardless of financial or insurance status. If necessary, we will work with you to make financial arrangements. However, please be aware that you will be required to pay for your initial office visit upon check-in. Our office will provide information on how to obtain coverage if needed. Please contact our office staff if you have any questions.

*How do I get a refill for my prescription?*

During office hours, you may call the office and follow the prompts for the refill line extension or you may request refills through patient portal.



### Release of Medical Records

**I give Wake Family Medicine and its staff permission to release information regarding my medical condition and treatment such as lab reports, test results, medications, diagnoses, prescriptions, medical records, etc. to the persons listed below**

**(Ex: Spouse, family member, friend, caregiver)**

I understand that if I want to make any changes regarding release of my information, I must notify Wake Family Medicine and its staff in writing. I do not have to sign this authorization in order to receive treatment from Wake Family Medicine. The practice will not receive payment from a third party in exchange for using or disclosing protected health information.

Name	Relationship to Patient
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

\_\_\_\_\_  
**Signature of Patient**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
Signature of Parent/Guardian if Patient is a Minor

\_\_\_\_\_  
Date

### Voicemail Confidentiality

On which number may we leave **any message (including lab reports and test results)** on your voicemail?

- Home       Work       Cell

On which number do you wish us to **only** leave a message to call our office?

Home       Work       Cell

### Financial Agreement

- Wake Family Medicine requires a 24-hour advance notice for appointment cancellations. There will be a 25.00 missed appointment fee for no shows.
- If you are more than 15 minutes late for your scheduled appointment, you will be asked to reschedule for a later date. Please be respectful of other patients who have arrived to their scheduled appointment on time.
- All copayments are due at the time of service. If you are unable to pay your copay at the time of service, we will need to reschedule your appointment until you are able to make payment. The copayment amount is a contract you have between your insurance carrier and we are contractually obligated to collect it at the time of service. In the event that your insurance coverage relates to a plan where we are not a participation provider, you will be 100% responsible for all charges incurred.
- All self-pay payments are due at the time of service.
- There will be a \$35 returned check charge applied to any check returned by your banking institution.
- We require you to bring your insurance card to each visit along with a valid identification. Please remember that we must receive your billing information at the time of each visit in order to meet claims submission guidelines set by your insurance plan. If either the practice or the plan fails to receive accurate information to process your claim, you will be held responsible.
- We will file your insurance as a courtesy, however if you do not have your insurance card at the time of service, we will expect payment for services rendered in full. We cannot accept insurance application forms as proof of insurance as it does not contain all of the necessary information to file your claims for reimbursement.
- Wake Family will make reasonable attempts to collect approved benefits from your carrier for a period of 60 days. However please remember that the patient or responsible party is ultimately responsible for the medical bill. You will receive a monthly statement showing the amount that is patient responsibility. Wake Family Medicine reserves the right to turn any and all accounts that are not paid in full within 90 days to a collection agency. There will be a \$20.00 fee assessed to the patient's account in collections.
- If you fail to receive an explanation of benefits (EOB or EOP) from your plan within 45 days of treatment, we suggest you contact your insurance plan. Payment not received in 60 days may be transition to patient responsibility.
- If you are scheduled for a yearly physical and also want to be seen for another problem at the same time, you will be asked to reschedule your physical so we can treat you for the problem, as your insurance may not cover both services on the same day.
- (Medicare Beneficiaries Only) I hereby certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct. I hereby authorize any holder of medical or other information about me to release to the Social Security Administration of its intermediaries or carriers any information needed for this or a related Medicare claim. I authorize that payment of authorized benefits be made to Wake Family Medicine.
- The patient or responsible party certifies that the information given is correct to the best of his/her knowledge.
- I understand that I may revoke this consent at any time except to the extent that the action based on this consent has already been taken. Consent for release of confidential information will expire automatically after one year from the date signed, except for the processing of financial claims.
- I have read and understand the financial policy stated above and agree to accept responsibility as described.





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• Patient Name or Responsible party	Patient/responsible party signature	DATE
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**Past Medical History**

**Major events, Hospitalizations, surgeries, or serious injuries:** (Please include the date and location you were treated.)

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

(Please indicate if you have – or have ever had – any of the following illnesses.)

- |  |  |  |                                       |
|--|--|--|---------------------------------------|
| <input type="checkbox"/> Anemia        | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Sinus problems  | <input type="checkbox"/> Cancer       |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Meningitis   |
| <input type="checkbox"/> Syphilis      | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Polio           | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Hepatitis     | <input type="checkbox"/> Rheumatic Fever     | <input type="checkbox"/> Thyroid Disease |                                       |
| <input type="checkbox"/> Seizure       | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Other           |                                       |

**Pregnancies** \_\_\_\_\_; Miscarriages/ Abortions \_\_\_\_\_; Any complications? Y/N (If yes, please explain)

**List your children with age and sex:**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**List all Allergies with reaction: (Medication, Food, and Latex)**

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

**Ongoing Medical Problems:**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_

**Family Medical History:** (ex: Mother, Father, Brother, Sister, etc.)

1. Cancer (Please list what type) \_\_\_\_\_
2. Diabetes \_\_\_\_\_
3. High Blood Pressure \_\_\_\_\_
4. Heart Disease/ Heart Attack \_\_\_\_\_
5. Mental Disease \_\_\_\_\_
6. Migraine Headaches \_\_\_\_\_
7. Seizures/ Epilepsy \_\_\_\_\_
8. Stroke \_\_\_\_\_
9. Tuberculosis \_\_\_\_\_
10. Kidney Failure/ Dialysis \_\_\_\_\_
11. Brain aneurysm \_\_\_\_\_
12. Other \_\_\_\_\_

**Social History:**

- Do you use tobacco products?  Yes  No If yes, what kind? \_\_\_\_\_  
If yes, for how many years and how much? \_\_\_\_\_  
If you smoked in the past, when did you quit? \_\_\_\_\_  
Do you drink alcoholic beverages?  Yes  No If yes, what kind? \_\_\_\_\_  
If yes, how much and how often? \_\_\_\_\_  
Do you use any recreational drugs?  Yes  No

**Nutritional History:** (ex: Vegetarian, Gluten free, Lactose intolerant, etc.)

\_\_\_\_\_  
\_\_\_\_\_

**Medications:** (Please list all medications, **including the strength and frequency**. Please include any vitamins, hormones, birth control pills, and over-the-counter products.)

1. \_\_\_\_\_
2. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

- |          |          |
|----------|----------|
| 3. _____ | 6. _____ |
| 7. _____ | 8. _____ |