RICHTER
Family Medicine
& Wellness

5500 W. Friendly Ave Ste. 201
Greensboro, NC 27410
Office: 336-897-0004 Fax 336-897-3003
richterfamilymedicinewellness@gmail.com

Chart _____

We are unable to complete any bloodwork or refill any medications prior to your first appointment with your provider. We will take care of these needs during your first visit.

By signing this form, you are acknowledging that you have read and understand our office policies.

Signature: _____ Date: _____

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Office Protocol

Please arrive 15 minutes prior to your appointment time, to allow time for check in.
Please bring the following with you to each of your visits:

- Insurance Card
- Prescription medicine bottles and over the counter medications you take - Copay
- Immunization Records

Please review all our office policies and sign at the bottom of this page.

Appointments

We ask that you allow plenty of time to get to our office for your appointments. If you arrive more than 15 minutes late for your appointment, then we will have to reschedule. We will strive to stay on time. From time to time, a patient emergency arises, and we may be running late for your visit. You may wait or have the option to re-schedule your visit. We will keep you informed of how long of a delay you may experience. We offer daily sick visit appointments for those unexpected acute illnesses. We ask that you call our office as early as possible for same day appointments. These spots fill quickly and are by availability only.

Missed Appointments

If you no-show for a new patient appointment, you may not be rescheduled. If you have three no-show appointments in a year, you may be discharged from the practice. We understand that appointments sometimes need to change, so we ask that you call in advance to cancel/re-schedule your appointment. If any emergency arises and you cannot make it to your appointment, please notify us or you may be charged a $25 fee for a no-show visit.

Copays

All copays and past due balances are expected at time of service, unless a prior agreement has been made with our office. You are financially responsible for any services not covered by your insurance.

Prescription Refills

For refills on your prescriptions, you must contact your pharmacy first. Your pharmacy will then contact us electronically for the refill request. We will not refill prescriptions without this request. Please allow us 48 hours to refill your prescriptions. We will not refill any medications after office hours or on weekends.

Richter Family Medicine and Wellness does not offer chronic pain management and will not dispense pain medications. We are happy to provide you with a referral to a pain management center. We reserve the right to obtain any information from the North Carolina Controlled Substance Reporting System at any time.

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Consent to Use and Disclose Protected Health Information

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we make of your protected health information, and off other important matters about your protected health information.

I, _____, have had full opportunity to read and consider the contents of the consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to Richter Family Medicine & Wellness to use and disclose my protected health information to carry out treatment, payment activities and health care operations.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation. Please understand that revocation of this Consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

Payment Policy: Thank you for choosing Richter Family Medicine & Wellness as your primary care provider. We are committed to providing you with quality and affordable health care. We participate with most insurance plans, including Medicare. **If you are insured by a plan, we do not participate with, payment is expected at time of service.** An updated insurance card is required each date of service. Some services are not covered by your insurance and will be the financial responsibility of the patient.

Patient Signature: _____ Date _____

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Authorization to Release Health Information

(Previous Primary Care Physician, Hospital, Diagnostic Center, ETC)

To: _____

Phone Number: _____

Fax Number: _____

Pursuant to my rights under HIPPA, I hereby request a copy of my Medical Records as a matter of urgency, and herby authorize you to finish and complete records prepared or obtained by you within the last 24 months, preferably via Fax Attention to:

Dr. Karen L Richter, MD
5500 W. Friendly Ave Ste 201
Greensboro, NC 27410
PH: 336-897-0004
Office Fax: 336-897-3003

Medical Records should include all Medical Information, including but not limited to MRI, X-ray, Pharmacy Records and Lab Results. For purposes of this Authorization, medical information specifically includes any confidential information regarding presence of HIV/AIDS, Drug Abuse, Disease, or Mental Health Status. I understand that:

1. I may refuse to sign this authorization that is strictly voluntary.
2. My treatment, payment and enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving this revocation.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy Regulation and may be re-disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable fee of ($10.00) if I ask for it.
6. I have kept a copy of this form after signing it.
7. The purpose of the release of these records is healthcare- related.

I have read and hereby authorize the release of this protected health information. The authorization is valid for One (1) year from this date set forth below.

Print Name: _____ Date: _____

Patient Signature: _____ DOB: _____

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Medical History Form

Name: _____ **DOB:** _____ **Age:** _____

Past Medical History (*examples: diabetes, high blood pressure, hypercholesterolemia*) If None: Check Here _____

1. _____ 6. _____ 11. _____
3. _____ 8. _____ 13. _____
4. _____ 9. _____ 14. _____
5. _____ 10. _____ 15. _____

Hospitalizations/ Surgeries: (*such as appendectomy or tonsillectomy*) If none: check here _____

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

Family History: (check all that apply) If no family history of medical problems, check here: _____

Problem:	High Blood Pressure	Diabetes	Heart Attack (What age)	Cholesterol	Stroke (What age)	Cancer/Type	Deceased
Father							
Mother							
Brother							
Sister							
Maternal Grand-mother							
Maternal Grandfa-ther							
Paternal Grand-mother							
Paternal Grandfa-ther							

Health Maintenance: Please indicate when the last time you had the following:

Mammogram	TDAP Vaccine
Pap smear	Flu Vaccine
Bone Density	Prevnar Vaccine
Colonoscopy	Pneumococcal Vaccine
Cologuard	Shingles Vaccine
Covid- 19 vaccine	Chicken Pox Vaccine

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Medical/Social History Form

Are you sexually active? Yes / No **If yes:** Men____ Women____ Both_____

Have you ever been abused? Yes / No **If yes:** Physically____ Sexually___ Verbally _____Emotionally ____

Alcohol Use: Yes / No **Drinks per week:** _____

Tobacco Use: Yes / No **Type:** Cigarettes / Pipe / Cigars

Smokeless Tobacco: Yes / No **Type:** Snuff / Chew

Children? YES / NO
If yes, Ages / Names: _____

Have you ever had any of the following? ***(Please check all that apply)***

___ Asthma
___ Arthritis
___ Blood in Stool
___ Cancer or Malignancy
___ Chicken Pox
___ Depression
___ Diabetes
___ Diverticulitis
___ Eating Disorder
___ Emphysema/ Chronic Bronchitis
___ Fainting Spells
___ Frequent Headaches
___ GERD/ Heartburn
___ Glaucoma
___ Genital Warts
___ Hay Fever/Allergies
___ Heart Arrhythmia
___ heart disease
___ Heart Murmur
___ Hepatitis/ Jaundice
___ High Blood Pressure
___ High Cholesterol
___ kidney disease
___ Migraines
___ Phlebitis or Blood Clots
___ Polyps in the Colon
___ Positive TB Skin Test
___ Rheumatic Fever
___ Blood Transfusion
___ Thyroid Problems
___ Stroke
___ Seizure or Epilepsy
___ Urine Incontinence
___ Urinary Tract Infections
___ Syphilis
___ Testing for HIV
___ Ulcers

Do you have any other significant illness, condition, or injury that you may think may be important to us to know about? Is there anything we missed? If so, please explain:

_____

_____

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Current Medications

Medication Name	Strength & Dose	How often is medication used?

Are you allergic to any medications? Yes / No

If yes, please list all medications that you are allergic to along with the reaction:

_____

Please list all other allergies: _____

_____

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Last Name: _____ First Name: _____ Middle Initial: ____

Address: _____

City: _____ State: _____ Zip code: _____

Home/Cell Phone: (_____) _____ Social Security #: _____

Date of Birth: _____ Age: _____ Marital Status: _____

Gender Identification: Male Female Other: _____

Employer / Employment Status: _____

Work Number:(_____) _____ Email Address: _____

Pharmacy: _____ Pharmacy Number: (____) _____

Emergency Contact Name: _____ Phone Number: (____) _____

Please tell us how you heard about us:

_____

INSURANCE INFORMATION:*(Please allow receptionist to photocopy your insurance ID Cards)*
(If someone other than patient is the insured party, please include date of birth and social security number for claims)
PRIMARY INSURANCE:

Plan Name: _____ Insured Name: _____

Insured's Social Security: _____

Policy/ID Number: _____Group #: _____ EFF Date: _____