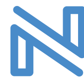


Gregory Narron M.D.
AND ASSOCIATES

PATIENT DEMOGRAPHIC

Please complete this form as completely and accurately as possible. Please print.

Patient Name (Last, First, Middle) ______________________________

Mailing Address (Street & P.O. Box) ______________________________

City ______________________ State ____________ Zip ____________

Birth Date ______________ Age ________ Sex ☐ M ☐ F SSN ______________

Phone ______________________________

E-mail ______________________________

Which provider(s) are you seeing? ☐ Narron ☐ Puryear ☐ Hendon

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Employment Status ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Retired ☐ Student

IF EMPLOYED, PLEASE COMPLETE THE FOLLOWING:

Employer Name ______________________ Phone ______________

Address ______________________________
Street *City* *State* *Zip*

PERSON RESPONSIBLE FOR PAYMENT (IF OTHER THAN PATIENT): ______________

Address ______________________________ Phone ______________
Street *City* *State* *Zip*

EMERGENCY CONTACT

Name ______________ Relationship ______________ Phone ______________

INSURANCE INFORMATION

Primary Insurance Company ______________________________

Policy Holder's Name ______________________ Date of Birth ______________

SSN ______________________________

ID# ______________________ Group Name/# ______________

Secondary Insurance Company ______________________________

Insured's Name ______________ Date of Birth ______________ SSN ______________

ID# ______________________ Group Name/# ______________

FINANCIAL POLICY

- Your insurance contract is an agreement between you and your insurance company. All charges incurred at Gregory Narron M.D. And Associates are your responsibility. Any disputes with the insurance company should be handled by you. You will be expected to pay your portion of the total charges at the time of service, even if we do participate with your insurance company. As a courtesy to you, we will file a claim to your insurance company "assigned" to us so the insurance portion will come directly to Gregory Narron M.D. And Associates . We will file your secondary insurance once we have received a response from your primary insurance. We will give the secondary 45 days to respond to the claim and if no response is received, the balance on the account will be turned over to you. It will become your responsibility to contact the secondary for payment. The secondary insurance will only be filed once, as a courtesy to you.

- Payment is due at check-in. We accept cash, personal checks and most major credit cards. There is a $30.00 charge assessed for all checks returned by your bank for non sufficient funds. If you are a self-pay (uninsured) patient, payment in full will be required at check-in for your initial visit. Payment plans on **past due** patient balances will be considered on a case-by-case basis. This should be discussed with a billing office representative and approved before your visit. When you check in your co-pay/co-insurance or deductible will be collected. However, there may be a balance once the insurance company responds to the claim which in that case we will bill you for that amount.

  *****Patients will not be permitted to carry a balance larger than $250.00. If your balance reaches $250.00 you will be required to pay in-full for any additional visits or charges.*****

- We consider an account delinquent if not paid within 30 days from billing date. After 90 days of nonpayment, further action may be taken to recover this delinquent account, i.e. a collection agency, and possible dismissal from the practice.

  ***** Patients with an appointment to see their provider, who have a delinquent balance of 60 days or more will be required to pay their existing balance in full before seeing the provider.*****

- I hereby authorize the provider to provide treatment as well as release any information required in the course of my examination or treatment. I authorize payment directly to the billing office of this provider for the medical benefits, if any, otherwise payable to me for services.

Please sign below that you have read, understand and will abide with this Gregory Narron M.D. And Associates Financial Policy and Consent to Treatment.

Printed Patient Name ______________________________

Patient Signature ______________________________

Date ______________________________

APPOINTMENT REMINDER SYSTEM

Our automated reminder system has several options. Please let us know the best way to contact you for these friendly reminders. You will receive either a text message or phone message 2 days before your appointment. It will be listed as a "do-not-reply" for texts.

Use the boxes to the left of each option to indicate your preference for receiving appointment reminders. If you prefer not to get appointment reminders please leave blank.

Home Email Address ______________________________

Phone (_____) ______ -______________, Please choose one option: ☐ Call or ☐ Text

CONFIDENTIAL COMMUNICATIONS

I hereby request that all communications, including voice messages from Gregory Narron, M.D. & Associates, PLLC be directed to the following:

Home (_____) ______ -______________ Cell (_____) ______ -______________ Business (_____) ______ - ______________

Please list names, relationship and phone numbers of anyone other than the patient that we are allowed to leave message with below:

____

____

This request will become effective as of the date below. Any changes to this information must be done by completion of a new Confidential Communications form by the responsible party. By signing the form, I am giving permission to Gregory Narron, M.D. & Associates, PLLC permission to contact me, including leaving messages if necessary concerning confirmation of appointments and to provide information about treatment issues at the above listed numbers.

PATIENT PORTAL

Please indicate below if you would like to be sent a link via email to sign up for the Patient Portal. The patient portal will allow you to be able to see appointment dates that you are scheduled for, change demographic information as well as communicate with the office thru secured messaging.

☐ Yes ☐ No

Signature: ______________________________ Date: ______________

PAYMENT AUTHORIZATION FORM

We are committed to meeting your healthcare needs and keeping your insurance and other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner for all our patients, we ask that you adhere to our practice's financial policy. By signing below, you are agreeing to its terms.

1. I am ultimately responsible for payment of charges for services I receive from this practice including those covered by my insurance. As a convenience, this practice will submit claims for reimbursement with my insurance provider; however, all payment responsibility is ultimately mine.
2. Some immediate payment may be expected at the time of service. This may include a co-pay and additional payment if this practice determines that the cost of my visit today will not be reimbursed by my insurance provider. This often happens if my deductible is not yet satisfied.
3. This practice may deny service or charge a service fee for failure to pay a co-pay at the time of service.
4. It is my responsibility to provide my current address, telephone number, email address, and insurance information at each visit.
5. I agree to provide the above practice and/or its designated payment agent with my debit/credit card or ACH information.
6. I understand that my signature and payment information will be maintained on file digitally for future use by the practice. The applicable payment card or ACH information will be truncated and "tokenized" by the payment agent in order to help maintain the security of my payment information. Card or ACH Information will be obtained through a card swipe, manual entry from card, void check, or orally in person or over the phone.
7. If warranted, this practice may offer the option of paying my share of costs via an automated payment plan. I understand that I may incur some interest expense beyond my balance in exchange for this convenience. I can avoid interest charges by paying my bill immediately if required or by its due date.
8. I authorize the above practice and/or its designated payment agent to apply charges to my payment card and/or ACH account for all amounts owed to the practice for medical visits, procedures or supplies, including (i) amounts agreed as part of a payment plan, (ii) copayments, (iii) coinsurance (after application of insurance proceeds), (iv) amounts not covered by insurance and/or (v) fees (if applicable) charged by the practice for failure to keep a scheduled appointment or provide timely notice of appointment cancellation.
9. In the case of a patient balance that is not satisfied by a charge to my payment method or a payment plan, I may receive a monthly statement for any outstanding balance. I am responsible for paying this balance by its due date in order to avoid paying possible interest on the balance.
10. Transaction receipts will be maintained in the patient file or will be emailed to me if I provide and maintain a valid email address.
11. I authorize the above practice and/or its designated provider to send electronic account statements and invoices to my email address on file. I understand that it is my responsibility to maintain a current email address on file and that I will not receive a mailed copy of any electronic statement.

This authorization will remain in effect until I provide written notice of cancellation to the practice. Authorization for services already rendered cannot be cancelled or refunded. I agree to notify the practice in writing of any changes in my payment or other information.

Name as it Appears on Card/ACH Account ______________________ Email Address ______________________

Billing Address ______________________ City __________ State ______ Zip ______

Phone Number ______________________

AUTHORIZED SIGNATURE ______________________ DATE __________

AGREEMENT TO PAY FOR SERVICES

I agree to pay for the services rendered by **GREGORY NARRON M.D. AND ASSOCIATES, PLLC**, as indicated below.

Payments will be made by **Credit Card** OR **Bank Draft at the time of service**, which I authorize you to use:

CREDIT CARD

Visa ______________________________ Exp ____________ CSC ________________

MasterCard __________________________ Exp ____________ CSC ________________

Other ______________________________ Exp ____________ CSC ________________

Name as appears on card ____

CHECKING ACCOUNT INFORMATION

Bank Name ____

Routing Number _______________________ Account Number _________________________

****Changes to the Credit Card or Checking information should be reported to the office IMMEDIATELY****

****It is understood that if the patient misses payments, without prior notification and agreement, the practice reserves the right to transfer BALANCE to a collection agency.****

Name of Patient (print or type) ____

Signature of Account Holder ________________________________ Date ________________

PATIENT STATEMENTS

In an effort to be more environmentally friendly, Gregory Narron M.D. And Associates now offers eStatements. Choosing this option allows you to receive your statements electronically, sent to you via email. You no longer have to hassle with paper statements. In addition to being environmentally friendly, eStatements are convenient and secure. As soon as your statement is ready, you will be notified via email. The email will provide a link to a secure website where you can not only view your statement, but can also choose one of several payment options.

Don't want to go paperless? Not a problem. If you would like to continue to receive paper statements in the mail, you'll be required to pay an annual fee of $20 which is due today.

Please let us know!

☐ Yes, I want the environmentally friendly option; instead of paper, please send my statements to:

____

☐ No, I would like to continue receiving paper statements, and will pay the annual fee of $20.

Patient Name ____

Guarantor/Patient Signature ______________________________ Date ________________

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review if carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.
We may use and disclose your medical records for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would include sending your records for a consultation with a specialist.
- **Payment** means such activities as obtaining reimbursement for service, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health Care Operations** include the business aspect of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example of this would be an internal quality assessment review.

We may contact you to provide appointment reminders or information about treatment issues, leaving a message if necessary. However, remembering your appointments is your responsibility. If you prefer to be contacted at an alternate address and/or telephone number, please notify our office in writing.

We also may communicate with you through email or text, we are making you aware that these communications will not be encrypted. HIPAA allows covered entities and their business associates to communicate e-PHI with patients via e-mails and texts if either (1) the e-mails and texts are encrypted and/or are otherwise secure; or (2) the covered entity or business associate first warns the patient that the communication is not secure and the patient elects to communicate via unsecure e-mail or text, anyway. When it comes to communicating with non-patients, the covered entity or business associate must generally ensure that its e-mail or texts comply with relevant Privacy and Security Rule standards.

Any other uses or disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your earlier authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to our Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified to you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations. For example, receiving billing and/or telephone calls or emails at an alternate address. You must request this in writing.
- The right to inspect and receive a copy of your protected health information, unless your provider deems this

information harmful to your health. This may be subject to certain limitations and fees. Due to the nature of mental health treatment, any interest in inspecting your record must be discussed with your provider first. Psychotherapy notes and raw test data resulting from psychological test administration are the property of the clinician. These are not part of the medical record and are not available for disclosure.

- The right to amend your protected health information. You must submit sufficient information to support your request for an amendment. This must be in writing. Any amendment cannot alter the original record.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

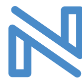
We are required by law to maintain the privacy of your protected health information and to provide you with the notice of our legal duties and privacy practices with the respect to protected health information.

This notice is effective as April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms and to make ne w notice provisions effective for all protected health information that we maintain. We will post this information and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office (see below for the address) or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

GREGORY NARRON M.D. AND ASSOCIATES
5 Kitchin Place, Suite 220
Asheville, NC 28803
Attn: Krystal Barber, Privacy Officer

THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, DC 20201


Gregory Narron M.D.
AND ASSOCIATES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name ______________________________ Date of Birth ______________

I have received a copy of the Notice of Privacy Practices for the above named practice.

Signature ______________________________ Date ______________

FOR OFFICE USE ONLY

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

☐ An emergency existed & a signature was not possible at the time.

☐ The individual refused to sign.

☐ A copy was mailed with a request for a signature by return mail.

☐ Unable to communicate with the patient for the following reason: ______________________

☐ Other: ______________________________