Gregory Narron M.D.
AND ASSOCIATES, PLLC

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

Referred By: _____

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 ☐ Fredericks ☐ 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/# _____

Patient Name_____ **Age**_____

What are the problem(s) for which you are seeking help?

1. _____
2. _____
3. _____

List ALL current prescription medications and how often you take them (if none, write none).
Medication Name / Total Daily Dosage / Estimated Start Date

_____

_____

_____

_____

Have you ever experienced any of the following?

Extreme depressed mood	☐ Yes ☐ No	Unexplained losses of time	☐ Yes ☐ No
Dramatic mood swings	☐ Yes ☐ No	Unexplained memory lapses	☐ Yes ☐ No
Rapid speech	☐ Yes ☐ No	Alcohol/substance abuse	☐ Yes ☐ No
Extreme anxiety	☐ Yes ☐ No	Frequent body complaints	☐ Yes ☐ No
Panic attacks	☐ Yes ☐ No	Eating disorder	☐ Yes ☐ No
Phobias	☐ Yes ☐ No	Body image problems	☐ Yes ☐ No
Sleep disturbances	☐ Yes ☐ No	Repetitive thoughts (e.g. obsessions)	☐ Yes ☐ No
Hallucinations	☐ Yes ☐ No	Repetitive behaviors (e.g. frequent checking, hand washing)	☐ Yes ☐ No

Check if you have ever tried the following
If yes, how long and when did you last use?

Methamphetamine	☐ Yes ☐ No	Pain Killers	☐ Yes ☐ No
Cocaine	☐ Yes ☐ No	Methadone	☐ Yes ☐ No
Stimulants (pills)	☐ Yes ☐ No	Tranquilizer/Sleeping Pills	☐ Yes ☐ No
Heroin	☐ Yes ☐ No	Ecstasy	☐ Yes ☐ No
LSD or Hallucinogens	☐ Yes ☐ No	Alcohol	☐ Yes ☐ No
Marijuana	☐ Yes ☐ No		

FAMILY MENTAL HEALTH HISTORY

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.) ***Please circle and list family member.***

Alcohol/Substance Abuse	☐ Yes ☐ No	Eating Disorders	☐ Yes ☐ No
Anxiety	☐ Yes ☐ No	Obsessive Compulsive Behavior	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Schizophrenia	☐ Yes ☐ No
Domestic Violence	☐ Yes ☐ No	Suicide Attempts	☐ Yes ☐ No

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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.

- 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.

- 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 _____

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AND ASSOCIATES, PLLC

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: _____

Gregory Narron M.D.
AND ASSOCIATES, PLLC

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 _____

Gregory Narron M.D.
AND ASSOCIATES, PLLC

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 _____

Gregory Narron M.D.
AND ASSOCIATES, PLLC

NO SHOW/LATE CANCELLATION POLICY

We, at Gregory Narron & Associates, understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice). You can cancel/reschedule appointments by calling the following number: 828.274.1415

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, if you have signed up for the appointment reminders they are automatically made/attempted two (2) business days prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY:

- **Please cancel you appointment with at least a 24 hours' notice within our normal business hours (Monday - Friday 8am-5pm): There is a waiting list to see the providers at our practice and whenever possible, we like to fill canceled spaces to shorten the waiting period for our patients.**
- **If less than a 24 hour cancellation is given, this will be documented as a "late cancellation" appointment and a fee of $20.00 will apply. If you do not present to the office for your appointment, this will be documented as a "No Show" appointment and a fee of $50.00 will apply.**
- **If it is a "New Patient Appointment" and you do not cancel or reschedule your appointment with at least the 24 hour notice, the "New Patient Deposit" is non-refundable.**
- **The payment information that we have on file will automatically be charged the "Late Cancel" or "No Show" appropriate fee's on the day of the missed appointment.**
- **For the "No Show" appointments, you may receive a phone call, letter or email. We will assist you to reschedule this appointment if needed. In the event we are unable to reach you, a voicemail will be left on the main contact number listed in the patient file.**
- **If you have multiple "No Show/Late Cancel" appointments, dismissal from the practice may be considered.**

I have read and understand the No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify the practice appropriately if I have difficulty keeping my scheduled appointments.

_____ _____

Patient Name **Date**

_____

Parent/Guardian (If Minor)

_____

Staff Signature

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 new 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, PLLC

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: _____