Triad Adult & Pediatric Medicine
Focused on Excellence, Devoted to Care

TAPM Offices

☐ **Pediatrics at Wendover:** *1046 East Wendover Avenue, Greensboro, NC 27405*
☐ **Family Medicine at N. Elm:** *606 N. Elm Street, High Point, NC 27260*
☐ **Family Medicine at Eugene:** *1002 South Eugene Street, Greensboro, NC 27406*
☐ **Family Medicine at Northwood:** 300 W. Northwood Street, Greensboro NC 27401
☐ **Family Medicine at Arlington**: 1205 Arlington Street, Greensboro NC 27406
☐ **Family Medicine at Brentwood:** *2039-109 B Brentwood St High Point, NC 27263*

New Patient Information Packet

TAPM is a federally funded community health center. TAPM is required to collect information on all patients' annual incomes. Please circle in the chart below the number of persons living within your home (household) and your annual income range. This information must be updated annually by all TAPM patients.

This information is used for internal purposes only and will not be disclosed to external sources/agencies/organizations.

2023 Federal Poverty Guidelines						
YEARLY INCOME						
Poverty Level Percentage						
People in Household	**0%-100% FPG**	**Greater than 100%**	**Greater than 125%**	**Greater than 150%**	**Greater than 175%**	**>200%**
1	≤$14,580	$14,581-$18,225	$18,226-$21,870	$21,875-$25,515	$25,516-$29,160	**≥$29,161**
2	≤$19,720	$19,241-$24,650	$24,651-$29,580	$29,581-$34,510	$34,511-$39,440	**≥$39,441**
3	≤$24,860	$24,861-$31,075	$31,076-$37,290	$37,291-$43,505	$43,506-$49,720	**≥$49,721**
4	≤$30,000	$30,001-$37,500	$37,501-$45,000	$45,001-$52,500	$52,501-$60,000	**≥$60,001**
5	≤$35,140	$35,141-$43,925	$43,926-$52,710	$52,711-$61,495	$61,496-$70,280	**≥$70,281**
6	≤$40, 280	$40,281-$50,350	$50,351-$60,420	$60,421-$70,490	$70,491-$80,560	**≥$80,561**
7	≤$45,420	$45,421-$56,775	$56,776-$68,130	$68,181-$79,485	$79,486-$90,840	**≥$90,841**
8*	≤$50,560	$50,561-$63,200	$63,201-$75,840	$75,841-$88,480	$88,481-$101,120	**≥$101,121**

The sliding fee scale below is for all medical, behavioral and nutritional services offered by TAPM.

NOMINAL FEE & COPAYMENTS	$20.00 NOMINAL FEE	$30.00 CO-PAYMENT	$40.00 CO-PAYMENT	$50.00 CO-PAYMENT	$60.00 CO-PAYMENT	Patient pays the full amount of the bill NO DISCOUNT
Poverty Level % Ranges	0%-100% FPG	100%-125%	126%-150%	151%-175%	176%-200%	>200%

***For family units with more than 8 members, add $4,540 for each additional member.**

Source: https://aspe.hhs.gov/poverty-guidelines

Patient/Responsible party's name and signature

Last Name: _____ **First:** _____ **M.I.** _____

Signature: _____

Date: _____ **Medical Record Number:** _____

Section 1: Patient Information

Last Name:_____ **First:**_____ **M.I.** _____

Date of Birth:_____ **Sex:** ☐Male ☐Female **Social Security#:**_____

Race: ☐Black/African-American ☐American Indian ☐Asian ☐Caucasian ☐Pacific Islander/Native Hawaiian ☐Other

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino **Language Spoken:** ☐English ☐Spanish ☐Other:_____

If Other, do you need an interpreter? ☐Yes ☐No

Patient's Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other

Patients Driver's License Number: _____ **Religion:** _____

Patient's Military Status: ☐Active ☐Retired ☐Veteran

Patient's Employment: ☐Full-time ☐Part-time ☐Self-employed ☐Unemployed ☐Disabled ☐Retired

Patient's Place of Employment: _____

For agricultural workers, are you: ☐Migrant ☐Seasonal ☐Employed Year-Round ☐Retired Farmworker

Preferred Pharmacy: _____

Patient's Street Address: _____ Zip**:** _____

Home phone number:_____ **Okay to call?** ☐Y ☐N **Okay to leave message?** ☐Y ☐N

Cell phone number:_____ **Okay to call?** ☐Y ☐N **Okay to leave message?** ☐Y ☐N

Work phone number:_____ **Okay to call?** ☐Y ☐N **Okay to leave message?** ☐Y ☐N

Email address:_____ **Okay to email?** ☐Y ☐N

How do you prefer we contact you? ☐Home Phone ☐Cell Phone ☐Work Phone ☐Text ☐Email ☐Other:_____

Do you live in public housing? ☐Yes ☐No -- If yes: ☐Family tenant ☐Senior housing ☐Section 8 ☐Vicinity of Section 8

Are you homeless? ☐Yes ☐No If yes: Approximately what date did you become homeless? _____ Which of the following best describes where you are staying? ☐Doubling up ☐Shelter ☐Transitional housing ☐Street/Vehicle ☐Other

Patient's emergency contact, Name: _____ **Phone:** ( ) _____

Parent or Person Responsible for Bill (complete only if different from above)

Last Name:_____ **First:**_____ **M.I.** _____

Date of Birth:_____ **Sex:** ☐Male ☐Female **Social Security#:**_____

Street Address:_____ **Zip:**_____

Parent's Military Status: ☐Active ☐Retired ☐Veteran

Parent's Employment: ☐Full-time ☐Part-time ☐Self-employed ☐Unemployed ☐Disabled ☐Retired

Parent's Place of Employment: _____

For agricultural workers, are you: ☐Migrant ☐Seasonal ☐Employed Year-Round ☐Retired Farmworker

Staff Only: Entered by: _____ Date:_____ Chart#:_____ Revised 7/13/2021

Section 2: Permission to Share Protected Health Information

HIPAA (Health Insurance Portability & Accountability Act of 1996) establishes guidelines to specifically protect your privacy by restricting information (oral, recorded, on paper, or sent electronically) about a patient's physical or mental/behavioral health, services given or payment for those services, and personal information connecting the patient to the records. In an effort to provide efficient, quality, patient-friendly medical care while ensuring patient privacy, we require permission for methods of contact that we may use for your Protected Health Information.

I give my permission for Triad Adult and Pediatric Medicine, its physicians and employees to contact and leave detailed messages specific to my/my child's medical care, including test results, on the phone number(s) I have provided. I understand that once a voicemail message exists it is no longer covered under HIPAA and therefore is not protected from unauthorized access. This permission begins as of the date signed below and will remain in effect until cancelled in writing by the patient/guardian. I understand that such revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

Please indicate any exception(s) to the above:_____

Signed:_____

(I am the: ☐Patient ☐Parent ☐Legal Guardian) **Date**

Patient's School/Daycare: _____ **Patient's Student Status:** ☐Full-time ☐Part-time

Which of the following below pertains to the patient:

I identify my gender as: ____Male ___Female ____Transgender Male/Female-to-Male ____Transgender Female-to-Male ____Other _____Choose not to disclose

I identify my sexual orientation as: ____Lesbian or Gay ____Straight (not lesbian or gay) ____Bi-sexual ____Something else ____Don't know ____Choose not to disclose

Section 3: Insurance Information

Please indicate which of the following applies to you/your child:

☐The patient is enrolled in the Triad Adult and Pediatric Medicine, Inc. sliding fee scale
☐ The patient is enrolled in the Guilford Community Care Network (has an orange card)

☐The patient has Medicaid/NC Health Choice; ID Number_____ ☐

The patient has the following private insurance coverage:

Type of Insurance _____ Co-pay Amount $_____

Policyholder's Employer_____Address_____

Policyholder's Name _____Group #_____Subscriber ID # _____

Patient's relationship to the insured? ☐Self ☐Child ☐Special Dependent ● Is a copy of card available? ☐Yes ☐No

This medical practice works with its patients to make paying for services easier. When you come in for your appointment, you will be asked to pay any unmet deductible amounts and/or co-payments, which your insurance company allows to be collected. We will file claims with your insurance company, so please make sure that insurance information is correct. Anything not covered by insurance will be the parent's/patient's responsibility.

PERMISSION TO RELEASE INFORMATION: Your signature below gives our organization permission to release all information regarding the patient's treatment, including information about behavioral health, to his/her insurance company/companies and to any other health care provider to which the patient may be referred. Also, signing this form gives permission to treatment and/or care management by the provider/practice and any other agency or person associated with the provider/practice involved with the patient's care and wellbeing.

Signed:_____

(I am the: ☐Patient ☐Parent ☐Legal Guardian) **Date**

PROMISE TO PAY ACCOUNT: For all services given by Triad Adult and Pediatric medicine, the patient or any responsible party that signs below agrees to pay all charges for the patient's account. I/we understand that I/we will be responsible for any and all charges not covered by private insurance, Medicare, Medicaid, indigent care program or any other federal, state or county agency. If I/we fail to pay any charges within thirty (30) days from date of service, I/we will be in default. If I/we default and an attorney is needed for collection, I/we agree to pay the attorney's fee of fifteen percent (15%) of the balance due. I/we will also pay any costs and other expenses gained in the collection of this account. Triad Adult and Pediatric Medicine may access my payment predictor score through Search America and/or my credit report to decide if I qualify for Financial Assistance.

Signed:_____

(I am the: ☐Patient ☐Parent ☐Legal Guardian) **Date**

Consent for Services ***Please complete the section below only if you are the parent/legal guardian of the patient****

As parent/legal guardian of patient named above, I understand my child cannot receive care at Triad Adult and Pediatric Medicine ('TAPM') with a non-guardian adult unless I have given written permission for this adult to bring my child. This permission also includes authorization for my child to receive immunizations during a visit with the adults listed below.

I authorize the following adults to bring my child for care in my absence:

Name of Individual	Relationship to Child	Phone Number

I also understand that I must bring my child for their first visit at TAPM to ensure an accurate medical history is given. I also agree for future visits to be available by telephone if not in person. The person who brings my child must also have a full understanding of the illness my child is coming in for. This person should also know other medical conditions and/or allergies my child has. I have the right to review TAPM's Notice of Privacy Practices before signing this consent form. I also understand that TAPM uses an automated telephone reminder system, and that calls will be made to my home or the home of one of the persons listed above when my child has a scheduled appointment.

Parent/Legal Guardian Signature: _____ Date Signed: _____

Parent/Legal Guardian Printed Name: _____ Witnessed by (staff initials): _____

Patient Name: _____

Date of Birth: _____ **Chart Number: _____**

Specialty Services Consent

Triad Adult and Pediatric Medicine, Inc. is an integrated, primary care medical home. This means that in addition to being a medical office that offers you primary care services, you agree as a part of our practice to receive additional on-site specialty care services through and recommended by the integrated health care team. Your integrated health care team could consist of a medical provider, nurse, certified medical assistant, specialty clinicians, and community liaison. Specialty care services may include screening, assessment and treatment in the following areas: Asthma, Behavioral Health, Developmental, Nephrology, Neurology, Nutrition/Dietetics, Podiatry, Psychiatry and/or other healthcare personnel in training. Specialty services are subject to change based on availability or access to specialty providers. Mental Health and Substance Use services may be subject to different confidentiality rules based on state and federal guidelines. Any patient is able to decline specialty services by informing a provider. The patient understands and acknowledges that no guarantee or assurance has been made as to the results that may be obtained from the specialty services. Specialty services may not be covered by your insurance and may result in the cost of the services being the patient's responsibility.

Patient/Legal Guardian Signature: _____ Date: _____

Patient/Legal Guardian Printed Name: _____

TAPM Representative Witnessed Signature: _____

Our Policies

We are dedicated to serving our patients and providing quality care. Please note the following standards:

Behavior – For your safety and the safety of others, we will not tolerate rude or inappropriate behavior at any of our facilities. We value our staff and our patients and aim to treat everyone with equal respect. **Displaying inappropriate behavior could result in having you or your child's care dismissed from our practice immediately.** Thank you for your help and support in keeping our facilities safe and patient-friendly.

Missed Appointments – It is important that our patients come to their scheduled appointments and arrive on time. If you are unable to come to your scheduled appointment, we ask that you contact our office 24 hours in advance so that we may adjust our schedules accordingly. If you fail to contact our office in advance, we will document the appointment missed as a 'no show' in the patient's record. Excessive no shows could negatively impact you or your child's ability to schedule appointments in the future, and possibly result in a discontinuation of our services.

Lateness – Patients arriving less than 10 minutes late will be seen at the provider's discretion, based on the flow of other patients in the office arriving on time. Patients arriving more than 10 minutes late for their appointment will be asked to reschedule in order to respect the time of our other patients, providers, and our clinical staff.

If you have questions, please ask to speak with the Practice Administrator at your respective location.

My signature below indicates my understanding of the policies listed.

Signed: _____

(I am the: ☐Patient ☐Parent ☐Legal Guardian) **Date**

Receipt of Notice of Privacy Practices and Written Acknowledgement:

I, _____, have received a copy of the Notice of Privacy Practices.

Signature of Patient: _____ Date: _____

Signature of Guardian: _____ Date: _____

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Authorization for Use/Disclosure of Protected Health Information

_____
Patient Name

_____ _____
Date of Birth Chart Number

I give permission to Triad Adult & Pediatric Medicine to release and receive the health information described below, including but not limited to information about diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental health, drug/alcohol/substance abuse, laboratory test results, medical history, treatment, or any such related information. I understand that if the person allowed to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal and state privacy regulations. By signing below, I agree to the release of the information, that the nature of this release has been discussed with me in a manner that I understand, and that I have had an opportunity to ask any questions about this release of information. This release is valid for one year from the date signed, and I understand that I may cancel this release in writing at any time except when action has been taken based on this consent.

Signature (I am the: ☐ Patient ☐ Parent ☐ Legal Guardian) Date Phone

Street Address City State

Witness Date Title

NOTICE: Triad Adult & Pediatric Medicine partners with other local health agencies in effort to better manage the health of the medically underserved and uninsured patient population in Guilford County. These agencies work together and may disclose medical information about you or your child. Please check any of the following listed agencies that you do not want Triad Adult & Pediatric Medicine to share medical information with: ☐Triad Adult & Pediatric Medicine (including Guilford Child Health, Family Medicine at Eugene, Family Medicine at Arlington, Family Medicine at Elm, Family Medicine at Brentwood, Family Medicine at Northwood) ☐Cone Health, ☐Guilford County Department of Social Services, ☐Guilford Community Care Network, ☐Guilford County Health Department, ☐Guilford Child Development, ☐Community Care North Carolina (CCNC), ☐Atrium Wake Forest ☐ Carolina Medical Home Network (CMHN), ☐Healthy Steps ☐Piedmont Health Services and Sickle Cell Agency ☐Congregational Social Work Education Initiative ☐Wake Health and ☐Wake Forest Baptist Health High Point Medical Center.

Agencies Exchanging Information

The released information is to be disclosed for the purpose of: _____

Information to be released (leave blank to release entire record): _____

Agency to release information:

_____
Name

_____
Mailing Address

_____
City State Zip

_____
Phone Fax

Agency to receive information:

_____
Name

_____
Mailing Address

_____
City State Zip

_____
Phone Fax

Staff Only:
☐Faxed ☐Mailed Date Processed: _____ Processed By (staff initials): _____