Phone 919-844-4552 Fax 919-844-4556

# Beverly Medical Center
## Dr. Beverly Goode-Kanawati
*Board Certified Family Practice & Board Certified Emergency Medicine*

6008 Creedmoor Road, Raleigh, NC 27612
BeverlyMedicalCenter.com
info@beverlymedicalcenter.com

Dear Patient:

Welcome to our practice and congratulations on taking a step towards total health. Dr. Goode-Kanawati D.O., Dr. Jignasa Sachar D.O. and Sandra Britt ANP-C primary goal is to address you as a whole not just your ailment or disease. Your initial exam is comprehensive and will take approximately an hour or more with either Dr. Goode-Kanawati D.O., Dr. Jignasa Sachar D.O. or Sandra Britt ANP-C After your exam you'll then spend another 20 to 30 minutes reviewing your instructions with a staff member. PLEASE COMPLETE ALL ENCLOSED FORMS PRIOR TO YOUR APPOINTMENT OR DOWNLOAD AND PRINT FROM THE INTERNET. In addition please bring your driver's license and insurance card as well.

If possible, Dr. Goode-Kanawati.Dr. Jignasa Sachar, and Sandra Britt ANP-C would like copies of all laboratory testing done within the last two years, including pap smears and mammograms for female patients. Please bring copies that we can keep. Please give these copies to a staff member when you arrive so that they may be added to your chart.

We require full payment at the time of your visit. We do not accept insurance, including Medicare. *However, we will provide a superbill for you to file the claim with your insurance company.* Because we are not a Medicare participating provider you **cannot** submit a superbill to Medicare. However, Medicare covers laboratory work and x-rays ordered by Dr. Goode outside of the office (most are done outside of the office).

We ask that in consideration of our chemical-sensitive patients please refrain from using scented personal care products or perfumes when you visit our office. We appreciate your cooperation in this matter. If you have any questions, please do not hesitate to call us. Also, for safety reasons please do not bring children to the office if they cannot be attended at all times.

Your appointment with Dr. Goode/Dr. Sachar/Sandra Britt ANP-C is on _____

(or the date and time stated in your e-mail).

**Our office will call you several days in advance to confirm your appointment. If we are unable to reach you please call our office at least 24 hours prior to your scheduled appointment to confirm (or cancel / reschedule if necessary). if we do not receive confirmation at least 24 hours in advance, your appointment will be cancelled and you will be billed for the office visit.**

We look forward to meeting you.

Sincerely,

Dr. Beverly Goode-Kanawati DO, Dr. Jignasa Sachar DO, Sandra Britt ANP-C & Staff

# REGISTRATION INFORMATION

Last Name _____ First Name _____ Middle Initial _____ Nickname _____

Street Address _____

City _____ State _____ ZIP Code _____

Home Phone Number _____ Cell Phone Number _____ E-Mail _____

Sex: ☐ Male ☐ Female Birth date _____ Age _____ Social Security # _____

Are you: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced Occupation _____

Employed By _____ Business Phone Number _____

Business Address _____

Name of Responsible Party (if minor) _____

Spouse Name _____ Occupation _____

Spouse Employer _____ Spouse Business Phone Number _____

Emergency Contact? _____

Pharmacy Name _____ Location _____ Phone Number _____

Compounding Pharmacy _____ Location _____ Phone Number _____

## INSURANCE INFORMATION

Primary Insurance Co. Name _____ ID # _____

Subscriber Name _____ Patient Relationship to Responsible Party: ☐ Self ☐ Spouse ☐ Child

Secondary Insurance Co. Name _____ ID # _____

Subscriber Name _____ Patient Relationship to Responsible Party: ☐ Self ☐ Spouse ☐ Child

## VOICE MAIL CONSENT

In order to get back to our patients as soon as possible, it is sometimes necessary to leave a voice message. However, we wish to respect your privacy and confidentiality. Please indicate which numbers can have which types of messages left at them, and we will be better able to serve you.

Is it okay to leave voice messages concerning appointments (scheduling and confirmation) at:

Home: ☐ Yes ☐ No Phone Number _____

Work: ☐ Yes ☐ No Phone Number _____

Cell: ☐ Yes ☐ No Phone Number _____

E-Mail: ☐ Yes ☐ No E-Mail _____

Is it okay to leave voice messages concerning prescriptions and other medical questions or information at:

Home: ☐ Yes ☐ No Phone Number _____

Work: ☐ Yes ☐ No Phone Number _____

Cell: ☐ Yes ☐ No Phone Number _____

E-Mail: ☐ Yes ☐ No E-Mail _____

**By signing below, I authorize that I have read and understand the Voice Mail Policies for Beverly Medical Center, and I agree to the above terms and conditions.**

**Name**(Print) _____

**Signature**_____ **Date**_____

**Witness**_____ **Date**_____

Last Name _____ First Name _____ Middle Initial _____ Nickname _____

## Assignment of Insurance Benefits

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered, or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. Beverly Medical Center is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment and health care operations. Beverly Medical Center promises to maintain the privacy of your health information as required by law.

_____ _____

Authorized signature of Subscriber Date

## Consent for Services

As a condition of your treatment by this office, payment in full is expected and must be paid at the time services are rendered.

Patients who carry medical insurance understand that all medical services furnished are charged directly to the patient and that he or she is personally responsible for payment of all medical services. This medical office cannot render service on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for the medical care is subject to change at any time.

In consideration for the professional services rendered to me, or at my request, by the doctor, I agree to pay the fee of said services to said doctor, or his assignee, at the time said services are rendered. I further agree that a waiver of any breech of any time or condition hereunder shall not constitute a waiver of any further term or condition. I further agree to pay all collection costs and reasonable attorney fees if suit be instituted hereunder.

I grant permission to you or your assignee to telephone me at home or at work to discuss matters related to the form.

I have read the above conditions of treatment and agree to their content.

_____ _____

Signature of patient or responsible party if minor patient Date

Whom may we thank for referring you to our practice?

☐ Another Patient ☐ Relative ☐ Friend ☐ Medical Office ☐ Newspaper ☐ Yellow Pages

☐ School ☐ Work ☐ Health & Healing ☐ Online Other _____

Specify name of person referring you, if our patient: _____

# NOTICE OF PRIVACY PRACTICES FOR BEVERLY MEDICAL CENTER

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

Protected health information is in the information we create and obtain in providing our services to you. This information may include documenting your symptoms, vital signs, examination and test results, diagnoses, treatment, and future care or treatment.

Beverly Medical Center is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations.

Examples of uses of your health information for treatment purposes are:

- The nurse obtains treatment information about you and records it in your medical record.
- During the course of your treatment, the physician determines she will need to refer you to a specialist for further consultation/tests. Beverly Medical Center will share your information, relating to the specific condition, with the specialist.

An example of use of your health information for payment purposes are:

- Health insurance companies will submit medical record requests in order to complete claim processing for repayment to the patient for paying out of pocket. Beverly Medical Center will then provide information to them about you and the care given.

An example of use of your health information for health care operations are:

- We obtain services from our insurers or other business associates such as quality improvement, training programs, credentialing, medical review, legal services, and insurance. Beverly Medical Center will provide such associates or insurers with patient's i nformation as necessary to obtain these services.

## Your Health Information Rights

The health and billing records we maintain are the physical property of Beverly Medical Center. The information in it, however, belongs to you, the patient. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office-we are not required to grant the request but we will comply with any request granted.
- Obtain a paper copy of the Notice of Privacy Practices by making a request at our office.
- Request that you be allowed to inspect and copy your health record and keep invoice records-you may exercise this right by delivering the request in writing to our office using the form we provide to you upon request.
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office using the form we provide to you upon request. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request.
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivery of a written revocation to our office.

If you want to exercise any of the above rights, please contact the Office Manager at 919-844-4552 or 6008 Creedmoor Road, Raleigh, NC 27613 in person or in writing during normal business hours. He/she will provide you with assistance on the steps to take to exercise your right.

## Our Responsibilities

Beverly Medical Center is required to:

- Maintain the privacy of your health information as required by law
- Provide you with a notice as to our duties and Privacy Practices as to the information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we cannot accommodate a requested restriction or request, and;
- Accommodate your reasonable requests regarding methods to communicate health information with you

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our "Notice." You are entitled to receive a revised copy of the "Notice" by calling and requesting a copy or by visiting our office and picking up a copy.

## To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact the Office Manager at 919-844-4552 or in writing or person at 6008 Creedmoor Road., Raleigh, NC 27613.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to the Office Manager. You may also email your complaint to info@beverlymedicalcenter.com

I have read and understand the above Notice of Privacy Practices for Beverly Medical Center, and agree to their content.

_____ _____

Signature of patient or responsible party if minor patient Date

_____

Printed Name of patient or responsible party if minor patient

_____ _____

Witness Signature Date

_____

Printed Witness Name