



Aegis
Medical
Center

A Division of Rao Clinic
1000 Crescent Green, Suite 102
Cary, NC 27518
Telephone: 919-233-0410
Fax: 919-233-0872

Patient Information

First _____ Middle Initial _____ Last Name _____

Prefers to be called _____ Date of Birth ____/____/____ Marital Status _____

Primary Address _____ City _____ State _____ Zip Code _____

Phone- Home: _____ Phone- Cell: _____ Other Phone: _____

Email Address: _____

Preferred Method of Contact: (Circle one): Phone Letter Email

Sex: Female _____ Male _____ Preferred Language: _____ Race: _____

Ethnicity: _____ Occupation: _____ Ethnicity: _____

Pharmacy: Name _____ Location _____

Pharmacy Phone umber _____

Emergency Contact: Name: _____ Relationship of Patient: _____

Phone Number of Emergency Contact: _____

Insurance:

I understand that, when possible, Aegis Medical Center will submit claims to my insurance company for payment directly to the practice. I acknowledge that it is my responsibility to understand my insurance coverage, including covered benefits, exclusions, deductibles, co-payments, co-insurance, prior authorization requirements, and network participation. I acknowledge that I am financially responsible for any services not covered by my insurance, as outlined in the attached Financial Policy. I understand that I am responsible for payment of all medical services provided by Aegis Medical Center and hereby assume and guarantee payment for all expenses incurred during my visit. If legal action becomes necessary to secure payment, I agree to pay all legal fees and associated costs incurred by the office.

Signature of Patient/Guardian

Date



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Practice Policy

Aegis Medical Center is your home for medical care. We want you to consider us your home base for all medical care. We have implemented processes and procedures to partner with you and your family and other healthcare professionals to provide the highest quality of coordinated care. As a practice we provide evidence-based care.

HIPPA Notification

Aegis Medical Center has implemented the Health Information Portability Act to protect the privacy of the patient's health information.

Current Information

You are required to notify our staff of any changes in your patient information, such as insurance, benefits, employer, patient name, home address, email address and contact numbers. You will be asked to present your current insurance cards and your driver's license at each appointment.

Payment at Time of Service

If your insurance plan requires you to pay a co-pay, it will be collected during the check in process. Patients that fail to bring their co-pay, may be asked to reschedule their non-urgent appointment. If you do not have insurance and are paying out of pocket or do not have your insurance card, you will be required to pay in full at the time of service. We accept cash, personal checks, Mastercard, and VISA. Your insurance cards and your pharmacy card must be presented at each visit. I acknowledge that it is my responsibility to understand my insurance coverage, including covered benefits, exclusions, deductibles, co-payments, co-insurance, prior authorization requirements, and network participation.

Claims Filing

Patients will receive billing statements from our office. **Payment in full is expected upon receipt.** If your account is referred to an outside collection agency due to non-payment, an additional fee will be added to your account to cover agency expenses. If you receive a statement, you do not understand, please contact our billing department so we can help resolve the issue.

Patient Billing and Collections

Patients will receive statements from our office patients and are expected to remit full payment upon receipt. If your account must be referred to an outside agency for non-payment, a fee will be added to your account to cover the expense incurred by the agency. If you received a billing statement that you do not understand, please contact our billing department so they can help to resolve the issue.

After Hours Calls

Our practice provides after-hours coverage for urgent medical needs. If the on-call provider determines that the issue is **not an emergency**, a **\$35.00 after-hours charge** may be added to your account. This fee is **not reimbursable** by your insurance company.

Late Policy

We ask that you arrive on time for your scheduled appointment. The practice reserves the right to reschedule patients who arrive **15 minutes or more** past their appointment time. For same-day sick appointments, arriving on time is required.

Patient/Guardian Signature

Date



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HIPPA Policy

I, understand that as a part of my healthcare, Aegis Medical Center originates and maintains electronic records pertaining to my health history, symptoms, examinations and test results, diagnosis, treatment plans for further care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals that contribute to my care
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which third-party payers can verify that services billed were actually provided
- A tool for routine healthcare operations such as quality assessment and review of the competence of healthcare professionals

I understand I have the right to request a copy of Aegis Medical Center Privacy Policies which provide a more complete description of how my information may be used or disclosed. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to using my health information for directory purposes
- The right of request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations

I understand that Aegis Medical Center is not required to agree to the requested restrictions. I also understand that I may revoke this consent in writing at any time, except to the extent that action has already been taken in reliance on this consent. I understand that if I refuse to sign, or if I revoke this consent, Aegis Medical Center may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Aegis Medical Center reserves the right to change its Notice of Privacy Practices and Practice Policies in accordance with Section 164.520 of the Code of Federal Regulations. Should any changes occur, Aegis Medical Center will provide me with a revised Notice via mail or email, as provided.

I authorize Aegis Medical Center to disclose my health information to:

Name _____ Relationship to Patient _____
Name _____ Relationship to Patient _____

I understand that as part of organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity and I consent to such disclosure for these permitted uses, including disclosure via fax.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

I understand that the medical provider to whom this authorization is furnished may not condition my treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.

I understand that if my medical record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol or substance abuse treatment, psychological or psychiatric conditions, or genetic testing, this authorization will include disclosure of such information unless I specifically indicate otherwise below.

If I do not wish for certain sensitive information to be disclosed, I understand that I must notify the practice in writing and specify the information I do not authorize for release.

I, fully understand and accept the terms of this consent:

I, fully understand and decline the terms of this consent:

Patient/Guardian Signature

Date

Witness Signature

Date



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Financial Policy

Co-Payments, Outstanding Balance and Fee

All co-payments, outstanding balances and fees for service not covered by your insurance policy are due at the time services are rendered. If you have questions regarding coverage for any services or treatments, we encourage you to contact your insurance carrier directly. For your convenience, we accept all major credit cards, debit cards, checks, and cash.

Self- Pay

Patients without insurance coverage will be required to pay for all services at the time they are rendered. We do offer a discounted rate to Self-Pay patients.

Returned Checks

A \$35.00 fee will be charged on all returned checks. In addition, we will no longer accept checks from you or any members of your family.

Insurance Collection

Your medical insurance policy is a contract between you and your insurance carrier and coverage may vary between individuals—even under the same insurance company. Our providers should not be expected to know your specific insurance benefits, coverage terms, or limitations, and any opinion offered should not be interpreted as a guarantee of coverage. I acknowledge that it is my responsibility to understand my insurance coverage, including covered benefits, exclusions, deductibles, co-payments, co-insurance, prior authorization requirements, and network participation. As a courtesy, we will bill your insurance carrier for services we provide. We are diligent in ensuring claims are filed accurately and promptly. It is **your responsibility** to provide us with your most current insurance card, demographic information, and contact information. If your insurance cannot be verified at the time of service, **you will be responsible for payment at that visit**. You are responsible for any remaining balance after your insurance has processed your claim (typically within 60–90 days). If your insurance carrier reimburses us at a later date, we will promptly issue a refund to you.

Patient Form Charges

We charge for the completion of several types of forms and correspondence. Fees are strictly based on the amount of time required to fulfill the requirements. (Example Disability forms and letters) Charges for these services will range from \$25.00 for a basic form, varying depending on the amount of time required by the Provider to complete the request.

Transfer of Care

When transferring care to another provider, all outstanding balances must be paid in full before medical records are released. charges for medical records will be assessed in accordance with **North Carolina General Statutes**. Payment is due at the time the request is made.

After Hours Calls

If the on-call provider is contacted after hours and the call is deemed **not an emergency**, a **\$35.00** fee will be added to your account. This fee is **not covered by insurance**.

Authorizations

I agree to be responsible for all medical expenses regardless of insurance coverage. I authorize my insurance company, attorney, or any other responsible party to pay Aegis Medical Center and/or its providers directly for services rendered. I authorize the release of any information necessary for payment of my bill.

If my account becomes delinquent, I agree to pay all costs associated with collection, including reasonable attorney's fees. I authorize the physician in charge to administer medical care as needed and to release information regarding my medical condition to parties involved in my treatment.

I have read, understood and agree to this financial policy as stated above and I accept responsibility for any balance not covered by my insurance company.

Patient or Guardian Signature

Date



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Cancellation Policy

Aegis Medical Center understands that there may be times when you are unable to attend your scheduled appointment. When this occurs, we kindly ask that you provide at least **24 hours' notice**. This allows us to offer the appointment time to another patient. Missed appointments represent a cost to you, to our providers, and to other patients who could have been seen during the time reserved for you.

To assist you, Aegis Medical Center sends reminder calls, text messages, and/or email notifications prior to your appointment. However, it remains the **sole responsibility of the patient** to remember and keep scheduled appointments.

Due to the increasing number of appointments that are missed without proper cancellation, Aegis Medical Center has implemented the following written cancellation policy:

Missed Appointment Fees

- **1st Missed Appointment:** Excused
- **2nd Missed Appointment:** \$35.00
- **3rd Missed Appointment:** \$50.00
- **Same-Day Appointment (missed):** \$50.00
- **Well Visits/Physicals (missed):** \$45.00

After the **third missed appointment**, you will receive a warning letter. Aegis Medical Center reserves the right to dismiss any patient who repeatedly fails to meet this policy or who refuses to sign this agreement.

I hereby declare that I have read, understand, and agree to adhere to the cancellation policy as stated above.

Patient/Responsible Party

Date



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Protected Health Information Designation Form

I _____ give my permission for Aegis Medical Center to release any of the following information about my medical condition, financial account and prescriptions as specified below:

Patient Preferred Contact Preference:

Phone Number: _____ May leave a detailed message: _____ YES _____ NO

Email Address:: _____

Name and Phone Number of Person Name: _____ Phone Number: _____	Information to be Released _____ Financial _____ Medical Information _____ Medications
Name and Phone Number of Person Name: _____ Phone Number: _____	Information to be Released _____ Financial _____ Medical Information _____ Medications
Name and Phone Number of Person Name: _____ Phone Number: _____	Information to be Released _____ Financial _____ Medical Information _____ Medications

In the case of a medical emergency, or in situations otherwise permitted or required by law, written authorization will not be necessary for the use or disclosure of your protected health information. Please refer to our Notice of Privacy Practices for additional information. You may request changes to your protected health information at any time by submitting a written request.

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Relationship, if Other Than the Patient: _____