Welcome to Carolina Prime Internal Medicine (CAROLINA PRIME), the office of Boyan Georgiev MD. We are pleased that you have chosen our office for your healthcare services. Our providers and staff are devoted to making your visit here as pleasant as possible. This letter and all items included in this welcome packet are designed to help you make a smooth transition into being a patient in our office.

At Carolina Prime Internal Medicine, you can expect to receive care that is based on the Patient Centered Medical Home model of care. This means that you will receive care that is carefully designed around evidence-based practice guidelines to assist you in reaching your best possible health status. It also means that we are committed to providing you with the health education and support needed to help you manage any chronic conditions that you have on a daily basis. At CAROLINA PRIME , you will be a partner in your health care and will be involved in every decision regarding your plan of care.

The selection of a primary care provider is a very important part of Patient Centered Medical Home and is one of the keys to providing you with the most coordinated care possible. Your provider and the health care team that surrounds them will work hard to know you as a person and to coordinate all aspects of the care that you receive both at our offices and through other health care providers. If you have not selected a primary care provider, you will be asked to let us know which provider you would like to choose as your primary care provider.

In a Medical Home your primary care provider is the hub of your medical care. We strive to be available to serve you at all times. We encourage you to call us at any time you need medical advice before going to an urgent care or emergency room. All calls to our office are answered based on urgency of the call and all calls will be answered within 24 hours. Any non-urgent requests for information can also be made through our patient portal. All portal messages are answered within 24 hours. Please do not utilize the portal for urgent or emergent messages. During hours that our office is closed, you can reach one of our providers through our after-hours on-call system by telephoning the regular office number and leaving a message with the telephone service. You will receive a call from a provider within 15 minutes.

We are concerned for your overall health. Any care that you receive at other locations should be incorporated into your overall plan for health and well-being. In order to provide you with the best care possible it is important for us to understand all aspects of your care. Sharing information about visits to other providers will allow us to coordinate your care across sites and specialties. Please let us know at each visit if you have had a visit to a hospital, emergency room, urgent care or specialty provider. If possible, please bring information about this care to your visit so that we can incorporate the information into your record and your treatment plan. Please also bring the results of any testing that is completed outside of our office, to include eye exams and podiatry exams if you have diabetes, so that we can include this information in your complete medical record.

As a patient you will receive a Clinical Summary containing information about your visit each time you leave our offices after a visit. The Clinical Summary will provide you with a record of the care that you received at that visit. Depending on your healthcare needs, it may also contain a copy of the care plan that you have developed with your provider. We urge you to create a folder in which to store these Clinical Summaries and other important papers that you will receive from your health care team such as copies of your lab results and your current

medication list. This will allow you to store all of your personal medical information in one place. Bring this folder with you to your appointments with your providers here at CAROLINA PRIME so that you can add your current information and keep it up to date. If you ever have the need to see a provider outside of Carolina Prime Internal Medicine, this folder can provide important information about your health care that the outside physician may not otherwise have access to.

At CAROLINA PRIME we realize that your healthcare does not stop when you leave our office. For this reason we have created a patient portal to help you manage your care in between visits to our office. We ask all patients to sign up for their portal at the end of their first visit. The portal is featured on our website and provides a way for you to access your information at all times. *MYQUEST* will allow you to access your lab results more quickly, see historical information, and have access to all of your visit information in one place from anywhere that you have an internet connection, including your smartphone. You can also utilize *MYQUEST* to request appointments and to ask your provider routine questions through email. At your initial visit to CAROLINA PRIME, you will automatically be given access codes to set up your personal page in *MYQUEST* . Detailed instructions are included in this packet. If you have questions about how to set up access to your *MYQUEST page, w*e will be happy to assist you to sign up.

If you must be seen at an urgent care center we encourage you to utilize Medac. We have a special agreement with the providers at this center to provide us with the information from your visit within 1 business day of your care. This allows us to seamlessly incorporate the informatin from this provider into your overall plan of care.

Medac Urgent Care	**Medac Urgent Care**	**Medac Urgent Care**	**Medac Urgent**
4402 Shipyard Blvd	**1442 Military Cutoff Rd**	**8115 Market Street**	**5245 South College Rd**
Wilmington, NC 28403	**Wilmington, NC 28403**	**Wilmington, NC 28411**	**Wilmington, NC 28412**
(910) 791- 0075	**(910) 256-6088**	**(910) 686-1972**	**(910) 392-7806**
8:00 AM - 11:00 PM	**8:00 AM - 8:00 PM**	**8:00 AM – 8:00 PM**	**8:00 AM – 8:00 PM**

If you must be seen in an emergency room or if you are hospitalized for any reason, please call us immediately after discharge to schedule a primary care follow-up visit. This will allow us to update your plan of care with any new information about your health.

Coordination of care is very important in a medical home model of care. Included in this packet you will find a specialist agreement. We ask that you share this agreement with any specialty care providers that you receive care from so that records can be shared between our offices. We have also partnered with certain behavioral health care providers in the community to ensure that care planning is coordinated for our patients receiving services. If you currently receive care from a behavioral health provider please let us know so that we can connect to coordinate your care.

If you take medications, please bring a written list or your bottles so that we can accurately record your medications. Please include any over-the-counter or herbal medications or supplements that you take. When you need a medication refill please call your pharmacy to request a prescription refill. The pharmacy will then contact our office and we will approve your refill within 2 business days of receiving the request from your pharmacy. Prescriptions are sent electronically (with the exception of controlled substances) to the pharmacy of your choice.

Thank you for choosing Carolina Prime Internal Medicine for your healthcare, we look forward to partnering with you to help you achieve your greatest health status possible.

Health History Questionnaire:

Name_____ Date of birth_____

Address_____

Local phone number_____ Alternative phone number_____

Please describe what problem or concern brought you to our office today:

☐ Primarily to establish care

☐ Other (please briefly describe)_____

Special Communication Needs:			
Language preference:			
If 'yes' to any of the questions below, how can we assist?			
Visual impairment	☐ Yes ☐ No	Cognitive impairment	☐ Yes ☐ No
Hearing impairment	☐ Yes ☐ No	Sensory impairment	☐ Yes ☐ No
Speech impairment	☐ Yes ☐ No	Other:	

Personal Health History		Previous Surgical Procedures	
Please check past or current problems or conditions		Please check if you have had any of the following	
Condition	Condition	Procedure	Year
☐ Hypertension	☐ Seizures	☐ Heart surgery	
☐ High cholesterol	☐ Headaches	☐ Carotid artery surgery	
☐ Diabetes	☐ Stroke	☐ Vascular surgery / stent	
☐ Heart attack or angina	☐ Prostate problem	☐ Abdominal aneurysm repair	
☐ Irregular heart rhythm	☐ Breast problem	☐ Hysterectomy	
☐ Congestive heart failure	☐ Urinary tract infections	☐ Gallbladder removed	
☐ Asthma	☐ Osteoarthritis	☐ Appendix removed	
☐ Emphysema or chronic bronchitis	☐ Cancer (Please list type)	☐ Tonsillectomy	
☐ Pneumonia	☐ Thyroid problem	☐ Joint replacement	
☐ Gastroesophageal reflux disease	☐ Bleeding disorder	☐ Breast cancer surgery	
☐ Stomach ulcer	☐ Addiction Issues	☐ Prostate cancer surgery	
☐ Kidney problems	☐ Depression or anxiety	☐ Hernia	
☐ Liver disease/hepatitis	☐ Mental Illness	☐ Pacemaker	
☐ Colon cancer	☐ Other (please describe)	☐ Other (please describe)	
☐ Bowel/digestive problem			

Social History:
Please circle appropriate answers below and provide explanations where appropriate
Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner
Education level: ☐ Did not Graduate ☐ High School ☐ Some College ☐ Bachelor's Degree ☐ Master's Degree or Higher
Occupation: Occupational concerns: ☐ Stress ☐ Hazardous substances ☐ Heavy lifting
How stressful would you rate your current living situation: (Circle number) No stress 0 1 2 3 4 5 6 7 8 9 10 Very Stressful
Are there financial concerns that affect your ability to seek healthcare? ☐ No ☐ Yes If yes, describe below
Are there any religious or cultural factors that you would like us to take into account when planning your healthcare?

Current Health Concerns

Please check problems or conditions that you are CURRENTLY experiencing

☐ Chest pain	☐ Rectal bleeding	☐ Eye pain	☐ Nervousness
☐ Shortness of breath	☐ Black/tarry stools	☐ Loss of vision	☐ Pain in testicles
☐ Wheezing	☐ Weight loss	☐ Double vision	☐ Loss of libido
☐ Cough	☐ Weight gain	☐ Memory loss	☐ Impotence
☐ Coughing up blood	☐ Loss of appetite	☐ Ringing in ears	☐ Breast pain
☐ Sore throat	☐ Difficulty swallowing	☐ Pain in ears	☐ Breast discharge
☐ Nasal congestion	☐ Diarrhea	☐ Nose bleeds	☐ Other (please describe below)
☐ Irregular heartbeat	☐ Constipation	☐ Hoarseness	
☐ Fast heartbeat	☐ Painful urination	☐ Easy bleeding	
☐ High blood pressure	☐ Blood in urine	☐ Easy bruising	
☐ Low blood pressure	☐ Urine frequency	☐ Rash	
☐ Lightheadedness	☐ Decrease in urine flow	☐ Changes in mole	**Females - Please complete**
☐ Dizziness/fainting	☐ Urine leakage	☐ Sore that won't heal	Menstrual flow:
☐ Abdominal pain	☐ Headache	☐ Fatigue/lethargy	☐ Reg. ☐ Irreg. ☐ Pain/cramps
☐ Heartburn	☐ Weakness	☐ Insomnia	Days of flow __ Length of cycle__
☐ Indigestion	☐ Loss of strength	☐ Forgetfulness	1st day of last period_____
☐ Ankle swelling	☐ Balance problems	☐ Depression	☐ Pain or bleeding after sex
☐ Nausea	Pain, weakness, or numbness in		Number of pregnancies ___
☐ Vomiting	☐ Arms ☐ Hips ☐ Back		Miscarriages___
☐ Vomiting blood	☐ Legs ☐ Neck ☐☐ Shoulders		Birth control method _____
☐ Change in bowel habits	☐ Hands ☐ Feet		

Family History

Relationship	Living Y/N	Age	Major Medical Problems and/or Cause of Death
Father			
Mother			
Siblings			
Children			

Specifically have any of your relatives had the following conditions

Condition	Relative		Condition	Relative
☐ Mental illness			☐ Chemical dependency	

Allergies:

Please list any allergies to medications or foods

Medications:	
Please list any medications that you take including over the counter medications, herbs, and supplements. Include dose and frequency	

Health Maintenance:					
Please check whether you have had the following preventive services and enter the year of the service					
Immunizations		Year	Tests		Year
Tetanus vaccine / Tdap	☐ Yes ☐ No		Pap smear/pelvic	☐ Yes ☐ No	
Pneumonia vaccine	☐ Yes ☐ No		Mammogram	☐ Yes ☐ No	
Influenza vaccine	☐ Yes ☐ No		Bone dexa	☐ Yes ☐ No	
Shingles vaccine	☐ Yes ☐ No		Colonoscopy	☐ Yes ☐ No	
			Prostate test	☐ Yes ☐ No	

Specialty Providers:	
In order that we can best coordinate your care, please list any medical providers you see outside of this practice and list the year that you last saw them	
☐ Eye doctor	☐ Nephrologist
☐ Cardiologist	☐ Psychiatrist
☐ Oncologist	☐ Allergist
☐ Urologist / Gynecologist	☐ Vascular
☐ Gastroenterologist	☐ Pulmonologist
☐ Endocrinologist	☐ Other

Health Behaviors:			
Tobacco use: ☐ Never ☐ Quit (when)_____ ☐ Current smoker			
If current smoker how many packs per day for how many years_____			
Alcohol intake: ☐ No ☐ Yes If yes how many drinks/how often_____			
Illicit drug use (including marijuana, cocaine, steroids): ☐ Never ☐ Past ☐ Current			
If past or current drug use describe:			
Exposure to secondhand smoke	☐ Yes ☐ No	Wear a seatbelt	☐ Yes ☐ No
Eat a diet high in fruits and vegetables	☐ Yes ☐ No	See a dentist at least once a year	☐ Yes ☐ No
Get 30 minutes of exercise 5 times a week	☐ Yes ☐ No	Wear sunscreen	☐ Yes ☐ No

Advance Care Planning:			
Do currently have, or would you like information on, any of the following items			
Living Will:	☐ Have	☐ Don't Have	☐ Want Information
Durable Power of Attorney:	☐ Have	☐ Don't Have	☐ Want Information
DNR Order:	☐ Have	☐ Don't Have	☐ Want Information
Other:	☐ Have	☐ Don't Have	☐ Want Information

Urinary Incontinence Assessment

Do you experience leaking in the following situations?

	Not at all	A little	Sometimes	A lot
During daily activities (work, household task)	☐	☐	☐	☐
During physical activities (walking, swimming, or other exercise)	☐	☐	☐	☐
During recreational activities (movies, hobbies)	☐	☐	☐	☐
During social activities (going out with friends, family visits)	☐	☐	☐	☐
During car trips	☐	☐	☐	☐

In the Past few Weeks:

Have you frequently experienced the need to urinate?	☐	☐	☐	☐
Have you experienced leaking before an urgent need to urinate?	☐	☐	☐	☐
Have you experienced leaking on effort, such as when sneezing, coughing, jumping, laughing, or during physical activity?	☐	☐	☐	☐
Have you experienced a pressing or immediate urge to urinate?	☐	☐	☐	☐
Have you noticed a change in your urination frequency?	☐	☐	☐	☐
Do you need to urinate more than 8 times every 24 hours?	☐	☐	☐	☐
Do you have to get up more than twice during the night to urinate?	☐	☐	☐	☐
Do you sometimes have to strain to urinate?	☐	☐	☐	☐

Fall Risk Screening

In the last 12 months have you fallen?	☐ Yes ☐ No ☐ Unsure
If yes, how many times?	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+
Were you injured as a result of this fall?	☐ Yes ☐ No ☐ Unsure

Mood Screening

A person's mood can have a strong influence on their health status and overall wellbeing.
Over the past 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things	Feeling down, depressed, or hopeless
☐ Not at all	☐ Not at all
☐ Several days	☐ Several days
☐ More than half the days	☐ More than half the days
☐ Nearly every day	☐ Nearly every day

Health Literacy Questionnaire

Many times in healthcare staff and providers use words that are unfamiliar to the general population. Please rate the following questions on a scale of 1 to 10; 1 being strongly disagree and 10 being strongly agree

I feel that I have a thorough understanding of the instructions that my doctors and nurses give me about my health	1 2 3 4 5 6 7 8 9 10
I feel that I remember the instructions given to me at my doctor's office when I get home	1 2 3 4 5 6 7 8 9 10
I feel that I have a strong understanding of medical language	1 2 3 4 5 6 7 8 9 10

Patient Signature:____ Date:_________________________________

Health History Questionnaire:

Name_____ Date of birth_____

Address_____

Local phone number_____ Alternative phone number_____

Please describe what problem or concern brought you to our office today:

☐ Primarily to establish care

☐ Other (please briefly describe)_____

Special Communication Needs:			
Language preference:			
If 'yes' to any of the questions below, how can we assist?			
Visual impairment	☐ Yes ☐ No	Cognitive impairment	☐ Yes ☐ No
Hearing impairment	☐ Yes ☐ No	Sensory impairment	☐ Yes ☐ No
Speech impairment	☐ Yes ☐ No	Other:	

Personal Health History		Previous Surgical Procedures	
Please check past or current problems or conditions		Please check if you have had any of the following	
Condition	Condition	Procedure	Year
☐ Hypertension	☐ Seizures	☐ Heart surgery	
☐ High cholesterol	☐ Headaches	☐ Carotid artery surgery	
☐ Diabetes	☐ Stroke	☐ Vascular surgery / stent	
☐ Heart attack or angina	☐ Prostate problem	☐ Abdominal aneurysm repair	
☐ Irregular heart rhythm	☐ Breast problem	☐ Hysterectomy	
☐ Congestive heart failure	☐ Urinary tract infections	☐ Gallbladder removed	
☐ Asthma	☐ Osteoarthritis	☐ Appendix removed	
☐ Emphysema or chronic bronchitis	☐ Cancer (Please list type)	☐ Tonsillectomy	
☐ Pneumonia	☐ Thyroid problem	☐ Joint replacement	
☐ Gastroesophageal reflux disease	☐ Bleeding disorder	☐ Breast cancer surgery	
☐ Stomach ulcer	☐ Addiction Issues	☐ Prostate cancer surgery	
☐ Kidney problems	☐ Depression or anxiety	☐ Hernia	
☐ Liver disease/hepatitis	☐ Mental Illness	☐ Pacemaker	
☐ Colon cancer	☐ Other (please describe)	☐ Other (please describe)	
☐ Bowel/digestive problem			

Social History:
Please circle appropriate answers below and provide explanations where appropriate
Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner
Education level: ☐ Did not Graduate ☐ High School ☐ Some College ☐ Bachelor's Degree ☐ Master's Degree or Higher
Occupation: Occupational concerns: ☐ Stress ☐ Hazardous substances ☐ Heavy lifting
How stressful would you rate your current living situation: (Circle number) No stress 0 1 2 3 4 5 6 7 8 9 10 Very Stressful
Are there financial concerns that affect your ability to seek healthcare? ☐ No ☐ Yes If yes, describe below
Are there any religious or cultural factors that you would like us to take into account when planning your healthcare?

Current Health Concerns

Please check problems or conditions that you are CURRENTLY experiencing

☐ Chest pain	☐ Rectal bleeding	☐ Eye pain	☐ Nervousness
☐ Shortness of breath	☐ Black/tarry stools	☐ Loss of vision	☐ Pain in testicles
☐ Wheezing	☐ Weight loss	☐ Double vision	☐ Loss of libido
☐ Cough	☐ Weight gain	☐ Memory loss	☐ Impotence
☐ Coughing up blood	☐ Loss of appetite	☐ Ringing in ears	☐ Breast pain
☐ Sore throat	☐ Difficulty swallowing	☐ Pain in ears	☐ Breast discharge
☐ Nasal congestion	☐ Diarrhea	☐ Nose bleeds	☐ Other (please describe below)
☐ Irregular heartbeat	☐ Constipation	☐ Hoarseness	
☐ Fast heartbeat	☐ Painful urination	☐ Easy bleeding	
☐ High blood pressure	☐ Blood in urine	☐ Easy bruising	
☐ Low blood pressure	☐ Urine frequency	☐ Rash	
☐ Lightheadedness	☐ Decrease in urine flow	☐ Changes in mole	**Females - Please complete**
☐ Dizziness/fainting	☐ Urine leakage	☐ Sore that won't heal	Menstrual flow:
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☐ Heartburn	☐ Weakness	☐ Insomnia	Days of flow __ Length of cycle__
☐ Indigestion	☐ Loss of strength	☐ Forgetfulness	1st day of last period_____
☐ Ankle swelling	☐ Balance problems	☐ Depression	☐ Pain or bleeding after sex
☐ Nausea	Pain, weakness, or numbness in		Number of pregnancies ___
☐ Vomiting	☐ Arms ☐ Hips ☐ Back		Miscarriages___
☐ Vomiting blood	☐ Legs ☐ Neck ☐☐ Shoulders		Birth control method _____
☐ Change in bowel habits	☐ Hands ☐ Feet		

Family History

Relationship	Living Y/N	Age	Major Medical Problems and/or Cause of Death
Father			
Mother			
Siblings			
Children			

Specifically have any of your relatives had the following conditions

Condition	Relative		Condition	Relative
☐ Mental illness			☐ Chemical dependency	

Allergies:

Please list any allergies to medications or foods

Medications:	
Please list any medications that you take including over the counter medications, herbs, and supplements. Include dose and frequency	

Health Maintenance:					
Please check whether you have had the following preventive services and enter the year of the service					
Immunizations		Year	Tests		Year
Tetanus vaccine / Tdap	☐ Yes ☐ No		Pap smear/pelvic	☐ Yes ☐ No	
Pneumonia vaccine	☐ Yes ☐ No		Mammogram	☐ Yes ☐ No	
Influenza vaccine	☐ Yes ☐ No		Bone dexa	☐ Yes ☐ No	
Shingles vaccine	☐ Yes ☐ No		Colonoscopy	☐ Yes ☐ No	
			Prostate test	☐ Yes ☐ No	

Specialty Providers:	
In order that we can best coordinate your care, please list any medical providers you see outside of this practice and list the year that you last saw them	
☐ Eye doctor	☐ Nephrologist
☐ Cardiologist	☐ Psychiatrist
☐ Oncologist	☐ Allergist
☐ Urologist / Gynecologist	☐ Vascular
☐ Gastroenterologist	☐ Pulmonologist
☐ Endocrinologist	☐ Other

Health Behaviors:			
Tobacco use: ☐ Never ☐ Quit (when)_____ ☐ Current smoker			
If current smoker how many packs per day for how many years_____			
Alcohol intake: ☐ No ☐ Yes If yes how many drinks/how often_____			
Illicit drug use (including marijuana, cocaine, steroids): ☐ Never ☐ Past ☐ Current			
If past or current drug use describe:			
Exposure to secondhand smoke	☐ Yes ☐ No	Wear a seatbelt	☐ Yes ☐ No
Eat a diet high in fruits and vegetables	☐ Yes ☐ No	See a dentist at least once a year	☐ Yes ☐ No
Get 30 minutes of exercise 5 times a week	☐ Yes ☐ No	Wear sunscreen	☐ Yes ☐ No

Advance Care Planning:			
Do currently have, or would you like information on, any of the following items			
Living Will:	☐ Have	☐ Don't Have	☐ Want Information
Durable Power of Attorney:	☐ Have	☐ Don't Have	☐ Want Information
DNR Order:	☐ Have	☐ Don't Have	☐ Want Information
Other:	☐ Have	☐ Don't Have	☐ Want Information

Urinary Incontinence Assessment

Do you experience leaking in the following situations?

	Not at all	A little	Sometimes	A lot
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During physical activities (walking, swimming, or other exercise)	☐	☐	☐	☐
During recreational activities (movies, hobbies)	☐	☐	☐	☐
During social activities (going out with friends, family visits)	☐	☐	☐	☐
During car trips	☐	☐	☐	☐

In the Past few Weeks:

Have you frequently experienced the need to urinate?	☐	☐	☐	☐
Have you experienced leaking before an urgent need to urinate?	☐	☐	☐	☐
Have you experienced leaking on effort, such as when sneezing, coughing, jumping, laughing, or during physical activity?	☐	☐	☐	☐
Have you experienced a pressing or immediate urge to urinate?	☐	☐	☐	☐
Have you noticed a change in your urination frequency?	☐	☐	☐	☐
Do you need to urinate more than 8 times every 24 hours?	☐	☐	☐	☐
Do you have to get up more than twice during the night to urinate?	☐	☐	☐	☐
Do you sometimes have to strain to urinate?	☐	☐	☐	☐

Fall Risk Screening

In the last 12 months have you fallen?	☐ Yes ☐ No ☐ Unsure
If yes, how many times?	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+
Were you injured as a result of this fall?	☐ Yes ☐ No ☐ Unsure

Mood Screening

A person's mood can have a strong influence on their health status and overall wellbeing.
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☐ Several days	☐ Several days
☐ More than half the days	☐ More than half the days
☐ Nearly every day	☐ Nearly every day

Health Literacy Questionnaire

Many times in healthcare staff and providers use words that are unfamiliar to the general population. Please rate the following questions on a scale of 1 to 10; 1 being strongly disagree and 10 being strongly agree

I feel that I have a thorough understanding of the instructions that my doctors and nurses give me about my health	1 2 3 4 5 6 7 8 9 10
I feel that I remember the instructions given to me at my doctor's office when I get home	1 2 3 4 5 6 7 8 9 10
I feel that I have a strong understanding of medical language	1 2 3 4 5 6 7 8 9 10

Patient Signature:_____ Date:_____

Carolina Prime Internal Medicine, PA
1908 Meeting Ct.
Wilmington, NC 28401
(910) 342-9969
Fax: (910) 342-9929
Emergency Contact Form

Date:_____

Name: Phone:

Address: Work Phone:
City: Cell Number:
Zip Code Email Address:

Date of Birth: / / Age:
Sex(M/F): SS#:

Marital Status:_____
Name of Spouse/Parent:
Spouse/Parent Work#:_

Employer:
Occupation:_____

Nearest relative not living with you to contact in case in **emergency:**

Name: _____

Phone: _____

Email: _____

Carolina Prime Internal Medicine, PA
1908 Meeting Ct.
Wilmington, NC 28401
(910) 342-9969
Fax: (910) 342-9929

Insurance Authorization and Assignment

I hereby authorize Carolina Prime Internal Medicine PA to furnish information to carriers, my employer, if applicable or the Heath Care Financing Administration, and its agents concerning my illness and its treatments. I authorize insurance or Medicare benefits to the provider for services rendered, where applicable. I understand that I must pay my insurance co-pay or for the total charges at the time of the visit valid as the original. I acknowledge that 24 hours advance notice must be given if unable to keep a scheduled appointment. Repeated failure to keep scheduled appointments without proper notice could result in a fine of $50.00 being charged to your account.

FULL PAYMENT OR INSURANCE CO-PAYMENT IS DUE AT TIME OF SERVICE, WE ACCEPT CASH, CHECK OR VISA/MASTERCARD

Usual and **Customary Rates:** Our practice is committed to providing the best treatments for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Minor Patients: The adult accompanying a minor and the parents (or guardian of the minor) is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/Mastercard or payment by cash or check at the time of service.

Patient's Signature: _____ Date: _____

Insured's Signature: _____ Date: _____

Carolina Prime Internal Medicine, PA
REQUEST FOR PRIVATE COMMUNICATION

Patient Name: _____

1. Where do you want to receive mail from us?
   a. ___Home Address _____

      _____

   b. ___Work Address _____

      _____

   c. ___ Alternate Address _____

      _____

We call for appointment reminders, follow-up appointments, and /or referrals. Please indicate by checking below your preferred location for calls.

__ Home Number _____

__ Leave a message on Machine

__ Leave message with whoever answers phone

__ Work Number _____

__ Leave Message with employer

__ Alternate Number _____

2. Please indicate below whom, other than yourself, is approved to access your information regarding appointments, medications, and referrals.
   __Spouse _____
   __Companion _____
   __Guardian _____
   __Family members _____

      _____

Patient Signature: _____ Date: _____

For Office Use Only: __Accept __Denies

Privacy Officer Signature: _____ Date: _____

Carolina Prime Internal Medicine, PA

Release of Medical Records

Patient Name:_____

Address:_____

_____

Date of Birth:___/___/_____ SS#:_____

Release From:	Send To:
_____	Boyan A. Georgiev, M.D.
_____	Carolina Prime Internal Medicine
_____	1908 Meeting Ct.
	Wilmington, NC 28401

Records Required: ( ) Lab Results

( ) X-Ray Results

( ) Complete Medical Record

( ) Other: Specify_____

- I understand that my records are confidential and cannot be disclosed without my written authorization, except otherwise provided by law.
- I also understand that I may revoke this authorization at any time except to the extent that action has been taken in advance of this consent and that, in any event, this authorization expires automatically as described below.
- This authorization expires in sixty (60) days from the date of my signature unless otherwise specified by date, event, or condition as follows:_____
- I understand that the information released could contain reference to, or results of HIV Antibody (AIDS) testing.

Signature of Patient:_____

Signature of Legal Representative:_____

Witness:_____

Date:_____

CAROLINA PRIME INTERNAL MEDICINE, PA

Boyan A. Georgiev, MD., F.A.A.C., M.A.A.C

Receipt of Notice of Privacy Practices

Written Acknowledgement Form.

I, _____, have received a copy of Carolina Prime Internal Medicine's Notice of Privacy Practices.

_____ _____

Signature of Patient Date

Dr. Georgiev
CAROLINA PRIME
INTERNAL MEDICINE

MEDICATION BOTTLES

INSURANCE CARDS

PICTURE ID

Please bring your medications in their bottles,

Your insurance cards, and a picture Id to

Every visit to our clinic.

Thank you,

Carolina Prime Internal Medicine P.A