McCRIMMON PRIMARY CARE plus

# NEW PATIENT REGISTRATION FORM

**PATIENT INFORMATION- Please Print**

**Legal Name (Last, Middle, First):** _____ **Suffix:** _____

**Date of Birth:** _____ **Email Address:** _____

**Home Address:** _____

**Primary Phone:** _____ **Alternative Phone:** _____

**Gender:** ϒ Male ϒ Female **Marital Status:** ϒ Single ϒ Married ϒ Widowed ϒ Παρτνερ

**Gender Identity:** ϒ Female ϒ Male ϒ non-conforming gender Other _____

ϒ Male-to- Female Transgender ϒ Female-to-Male Transgender

**Language:** ϒ English ϒ Spanish Other_____

**Race:** ϒ White ϒ Black/ African ϒ Hispanic Other_____

**RESPONSIBLE PARTY- Parent or Guardian (if patient is under 18 years old)**

**Legal Name (Last, Middle, First):** _____

**Relationship to Patient:** _____ **Date of Birth:** _____

**EMERGENCY CONTACT- Who may we contact in case of an emergency?**

**Name:** _____ **Relationship:** ϒSpouse ϒParent ϒOther_____

**Home Phone:** _____ **Cell Phone:** _____

**INSURANCE INFORMATION- Please allow receptionist to photocopy your insurance card**

**Primary Insurance:** _____ ϒ **No Insurance (Self-Pay)**

**Policy ID Number:** _____ **Group No.** _____

**Subscriber Name:** _____ **Subscriber Date of Birth:** _____

**Relationship:** ϒSelf ϒSpouse ϒParent

**Secondary Insurance:** _____ **Policy ID Number:** _____

**Group No.** _____ **Subscriber Name:** _____

**Subscriber Date of Birth:** _____ **Relationship:** ϒSelf ϒSpouse ϒParent

**PREFERRED PHARMACY**

**Name:** _____ **Address:** _____

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# Disclosure & Authorization to Release Health Information to Family/Friends

**Patient Name:** _____ **Date of Birth:** _____

**Purpose of this Form:** This form allows you to tell us who we may disclosure your medical care to. This includes permission to discuss appointments, test results, billing, or other parts of your care. **You do not have to list anyone.** Care will not be affected if you choose not to authorize anyone.

**Individuals Authorized to Receive Information:**

☐ **I do NOT authorize disclosure to any friends/family.**

| Name | Relationship | Phone Number | Information Allowed |
|---|---|---|---|
| _____ | _____ | _____ | ☐ ALL medical & billing info<br>☐ Medical info only<br>☐ Billing info only<br>☐ Other: _____ |
| **Name** | **Relationship** | **Phone Number** | **Information Allowed** |
| _____ | _____ | _____ | ☐ ALL medical & billing info<br>☐ Medical info only<br>☐ Billing info only<br>☐ Other: _____ |

**Specially Protected Information**

Unless you check **"NO,"** the people listed above may also receive the following if applicable:

Mental health information: ☐ **YES** ☐ **NO** HIV/STD testing or treatment: ☐ **YES** ☐ **NO**

Substance use treatment: ☐ **YES** ☐ **NO** Reproductive health information: ☐ **YES** ☐ **NO**

**Patient Signature**

By signing below, I acknowledge that I have read and understand this form, and I authorize McCrimmon Primary Care Plus to disclose my information as described above.

**Patient / Legal Guardian Signature:** _____

**Printed Name:** _____ **Date:** _____

**Relationship to Patient (if applicable):** _____

**Details & Expiration**

- This does not permit anyone listed to make medical decisions for me
- Treatment, payment, or eligibility for benefits does not depend on signing this form
- Anyone you authorize may receive information verbally, by phone, or in writing when appropriate.
- This authorization remains in effect until you revoke it in writing or complete a new form

**Office Use Only**

Received by staff: _____ Date: _____

Scanned: ☐ Yes Entered into EMR: ☐ Yes ☐ No

*Last Updated: 01/02/2026*

McCRIMMON PRIMARY CARE plus

## MCCRIMMON PRIMARY CARE PLUS GENERAL CONSENT & AGREEMENT SUMMARY

1. **General Treatment Consent:** I authorize McCrimmon Primary Care Plus providers to evaluate and treat me or my dependent(s) as medically appropriate. I may refuse any treatment and understand no outcomes are guaranteed.
2. **Communication Consent:** I consent to being contacted via mail, text, call, email, and automated messaging systems regarding healthcare, appointments, results, and billing.
3. **Financial Responsibilities:**
    - **Insurance & Patient Responsibility:** I authorize McCrimmon Primary Care Plus to bill my insurance. I understand I am responsible for copays, deductibles, non-covered services, and any balances not paid by my insurance.
    - **Late Fees & Collections:** Unpaid balances and no-show fees may incur additional charges and may be referred to collections. I am liable for collection costs. Repeated non-payment may result in dismissal from the practice.
    - **After-Hours Fees:** Insurance-defined after-hours codes may apply for evening, weekend, or holiday visits.
    - **Self-Pay / Out-of-Network:** If uninsured, out-of-network, or without proof of insurance, I agree to pay in full at the time of service.
4. **Late Policy:** Patients arriving more than 10 minutes late may be asked to reschedule unless the provider can accommodate the delay.
5. **Late Cancellation & Missed Appointments:** A $50 fee may apply for late cancellations or no-show appointments. Cancellations must be made at least **[insert correct timeframe]** before the appointment time.
6. **Prescriptions:** Please contact your pharmacy to fax refill requests to our office. Refill requests require 48–72 business hours; controlled substances require up to 5 business days. I authorize the release of my prescription history from pharmacies and pharmacy benefit managers.
7. **Forms:** Forms requiring medical review (school, camp, FMLA, disability, prior authorization letters, etc.) are completed within 7–10 business days. Urgent requests will be reviewed case-by-case.
8. **Vaccines:** We accept unvaccinated patients or those who decline routine childhood vaccines. For new pediatric patients, vaccine records must be uploaded at least 48 hours before the visit or the appointment may be rescheduled.
9. **Telehealth Consent:** I consent to receive telehealth services. My provider will verify my identity and location at each visit. I understand telehealth has limitations and an in-person visit may be required if medically necessary. Telehealth is not appropriate for emergencies; I should call 911 for emergency care.**Outside Records:** I authorize McCrimmon Primary Care Plus to obtain my medical records from other healthcare providers or health information exchanges (hospitals, specialists, etc.) as needed for my care, in compliance with HIPAA.
10. **Outside Records:** I authorize McCrimmon Primary Care Plus to obtain my medical records from other healthcare providers or health information exchanges (hospitals, specialists, etc.) as needed for my care, in compliance with HIPAA.
11. **Work Injuries:** McCrimmon Primary Care Plus does not handle Workers' Compensation cases.
12. **Minor-to-Adult Transition:** When a patient turns 18, they must sign their own consents. Parents or guardians will no longer have access unless the 18-year-old signs disclosure forms.
13. **ID & Photos:** I may be asked for photo ID. I consent to photography for identification and treatment purposes. Images will not be used for marketing.
14. **Revocation:** I may revoke this consent at any time in writing, except where action has already been taken.

*Last Updated: 01/02/2026*

# MCCRIMMON PRIMARY CARE PLUS: NOTICE OF PRIVACY PRACTICE (NPP)

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.**

**OUR PRIVACY OBLIGATIONS:** We are required by law to:

- Maintain the privacy of your protected health information (PHI).
- Provide this Notice explaining our privacy practices.
- Notify you if a breach of your PHI occurs.
- Follow the terms of this Notice.

**HOW WE MAY USE & DISCLOSE YOUR HEALTH INFORMATION**

We may use or disclose your PHI **without written authorization** for:

- **Treatment:** Providing and coordinating your care (e.g., sharing information with specialists, hospitals, pharmacies, labs, telehealth).
- **Payment:** Billing your insurance, determining coverage, obtaining prior authorization.
- **Healthcare Operations:** Quality improvement, audits, training, managing records, ensuring compliance.
- **Other Permitted Uses:** When required by law: public health reporting, abuse/neglect reporting, health oversight activities, court orders, law enforcement requests, coroner/medical examiner purposes, preventing serious threats, research (with safeguards), or workers' compensation cases.

**USES REQUIRING YOUR AUTHORIZATION:** We must obtain your written permission for:

- Psychotherapy notes
- Marketing
- Sale of PHI
- Disclosures not related to treatment, payment, or operations
- Release of information to individuals not involved in your care

You may revoke your authorization at any time in writing.

**YOUR RIGHTS:** You have the right to:

- **Access** and obtain a copy of your medical record.
- **Request an amendment** of incorrect or incomplete information.
- **Request confidential communications** in a specific manner or location.
- **Request restrictions** on how we use or disclose your PHI. (We must follow restrictions if you pay out-of-pocket in full and request nondisclosure to insurance.)
- **Receive an accounting** of certain disclosures made in the past 6 years.
- **Receive a paper copy** of this Notice at any time.
- **File a complaint** with us or with HHS if you believe your privacy rights were violated (you will not be penalized).

**CONTACT INFORMATION**

**Privacy Officer**

**McCrimmon Primary Care Plus**

Phone: 919-655-1000

Address: 6402 McCrimmon Parkway, Suite 100. Morrisville, NC 27560

You may also file a complaint with the U.S. Department of Health & Human Services (HHS).

*Last Updated: 01/02/2026*

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**CHANGES TO THIS NOTICE**

We may change this Notice at any time. Updated versions will be posted in our office and available upon request.

**NPP Effective Date: 8/1/2025**

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## CERTIFICATION & AUTHORIZATION

By signing below, I acknowledge that I have received, reviewed, or been offered a copy of the McCrimmon Primary Care Plus Notice of Privacy Practices, which explains how my health information may be used and disclosed. I understand that I may request a copy at any time.

I also acknowledge that I have reviewed and agree to the General Consent & Agreement Summary on this form. I authorize McCrimmon Primary Care Plus to provide medical evaluation and treatment, communicate with me as outlined, bill my insurance, and release information necessary for payment and healthcare operations. I understand my financial responsibilities and the policies described above.

This consent remains in effect until I revoke it in writing, except where action has already been taken.

_____ _____

**Signature of Patient/Authorized Individual** **Date**

_____ _____

**Patient Name** **Date of Birth**

If signed by a personal representative of the patient, please print name below and indicate relationship to the patient for Legal Guardian or Power of Attorney, please submit Legal Documentation with this form.

_____ _____

**Print Authorized Representative Name** **Relationship to Patient**