UNC HEALTH | Cary Orthopaedics

Physician: _____ Acct #: _____

PATIENT INFORMATION

Full Name:	Address:
Birth Date: Age:	
Sex: ☐ Male ☐ Female ☐ Other	City: State: Zip:
SS#:	Primary Phone #:
Employment Status:	Mobile Phone #:
Employer:	Email:
Retirement Date *(if applicable)*:	☐ I agree that COSM can EMAIL me secured HIPAA protected information to my email address
Work Phone #:	Preferred contact method for office communication. ☐ Primary ☐ Cell ☐ Email
Preferred Language:	Would you like appointment reminders through a third-party, how? ☐ Text ☐ Call ☐ Email ☐ Decline
Marital Status: ***Please check one*** ☐ Single ☐ Widowed ☐ Married ☐ Legally Separated ☐ Divorced ☐ Domestic Partner	Race: ***Please check one*** ☐ American Indian ☐ Other Pacific Islander ☐ Asian ☐ Unknown/Other ☐ Black/African American ☐ White/Caucasian
Spouse Name:	Are you in a nursing home facility? ☐
Spouse Phone #:	Ethnicity:
Spouse DOB:	☐ Hispanic/Latino ☐ Unknown
Emergency Contact:	☐ Non-Hispanic/Latino
Emergency Phone #:	**Pharmacy Name:**
Relationship to Contact:	**Pharmacy Location:**
Referring MD:	Family Doctor:
Referring MD Phone #:	Are you a minor? Y N
If Patient is a MINOR: ***Please complete this section***	
Parent/Legal Guardian Name:	
Parent/Legal Guardian DOB:	
Parent/Legal Guardian Phone #:	
Parent/Legal Guardian Address:	
Is Parent/Legal Guardian Guarantor? Y N	

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Policy Holder:	Policy Holder:
Policy Holder DOB:	Policy Holder DOB:

CHIEF COMPLAINT **Height:** _____ **Weight:** _____ **Hand Dominance**: Left Right

List Body Part(s):	☐ Left ☐ Right ☐ Bilateral
What date did the pain begin:	Is this due to an injury: Y N
Describe the pain/problem:	
Was the injury due to the following? ☐ Military Activity ☐ Volunteer ☐ Student ☐ Student Athlete ☐ Leisure	
Where would you rate your pain on a scale of 1-10? 1 2 3 4 5 6 7 8 9 10	
Will you be filing through Worker's Compensation, Auto Insurance, or Liability Insurance?	Y N
If yes, please give details (names, phone #s, claim #s, etc.):	

UNC HEALTH | Cary Orthopaedics

Acct #:_____

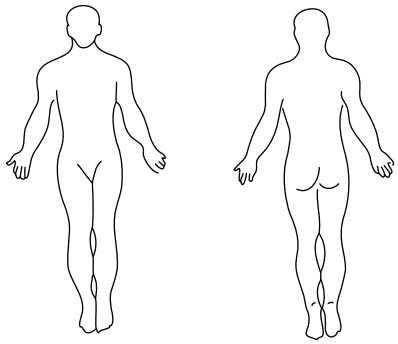
Patient Clinical Paperwork

Patient Name:_____ Date:_____ Age:_____

COVID Vaccine dates: Dose 1_____ Dose 2_____

Date of last Flu Vaccine_____ Date of last Pneumonia Vaccine_____

On the diagram, please mark where your pain is today.



Front Back

Please rate where your pain is TODAY.
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Ever)
Please rate where your pain has been on average over the LAST week.
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Ever)

PROCEDURES/TEST

Which of the following studies have been performed related to your chief complaint? If you have had any of these imaging studies, please bring the imaging CD, radiographs, and reports with you.

	Date	Location
X-rays		
CT Scans		
MRI		
Myelogram		
Bone Density Scan		
EMG/NCS		

	Date	Number of Visits Attended	Where	Body Part Treated	Helpful
Physical Therapy					(Yes/No)
Chiropractic Care					(Yes/No)

	Date	Location of Injection	Physician Performing Procedure	Helpful
Spinal Injections				(Yes/No)
Spinal Injections				(Yes/No)
Spinal Injections				(Yes/No)
Joint Injections				(Yes/No)
Joint Injections				(Yes/No)
Joint Injections				(Yes/No)

PAST MEDICAL HISTORY Acct #:_____

Do you have loss of your bowel and bladder function? ☐ Yes ☐ No

If yes when did the problem start? _____

Please check all major illness and conditions you have ever been diagnosed with.

☐ Acid Reflux	☐ Emphysema	☐ Kidney Disease	☐ Pulmonary Hypertension
☐ Anemia	☐ Environmental Allergies	☐ Kidney Stones	☐ Rheumatoid Arthritis
☐ Anesthesia Complications	☐ Epilepsy	☐ Liver Disease	☐ Sarcoidosis
☐ Aneurysm	☐ Fibromyalgia	☐ Lung Disease	☐ Scoliosis
☐ Anxiety/Depression	☐ GERD	☐ Lupus	☐ Seizures
☐ Asthma	☐ GI Bleeding	☐ Migraines/Headaches	☐ Sickle Cell Trait
☐ Bladder Problems	☐ Gout	☐ MRSA	☐ Sleep Apnea
☐ Bleeding Disorder	☐ Heart Attack	☐ MSSA	☐ Staph Infection
☐ Blood Clots/DVT	☐ Heart Failure	☐ Multiple Sclerosis	☐ Stents
☐ Broken Bones	☐ Heart Murmur	☐ Nerve Disorder	☐ Stroke
☐ Cancer | Type:	☐ Hepatitis B	☐ Osteoarthritis	☐ Thyroid Disease
☐ Cirrhosis	☐ Hepatitis C	☐ Osteopenia/Osteoporosis	☐ Tuberculosis
☐ COPD	☐ High Blood Pressure	☐ Pacemaker/Defibrillator	☐ Ulcers (GI)
☐ Coronary Artery Disease	☐ High Cholesterol	☐ Problems with Teeth	☐ Vascular Disease
☐ Cyst/Growth	☐ HIV/AIDS	☐ Psoriasis	☐ Other: _____
☐ Diabetes	☐ Irregular Heartbeat	☐ Pulmonary Embolism	☐ None:

SURGICAL HISTORY

Please list any surgeries including spine surgeries you have undergone:

Type of Surgery	Date	Performing Physician	Helpful
			(Yes/No)
			(Yes/No)
			(Yes/No)
			(Yes/No)
			(Yes/No)
			(Yes/No)

SOCIAL HISTORY

Education Level: ☐ Elem/Middle School ☐ High School ☐ College ☐ Masters/Doctorate

If disabled, for what diagnosis?_____

SMOKING STATUS

☐ Never Smoker

☐ Former Smoker Date when you stopped smoking: _____

☐ Current Smoker Packs Per Day: _____ Number of Years: _____

Do you use alcohol? ☐ Yes ☐ No If so, amount frequency? _____

Do you use caffeine? ☐ Yes ☐ No If so, amount frequency? _____

Do you have a history of or use recreational drugs? ☐ Yes ☐ No

Do you now or have a history of substance abuse? ☐ Yes ☐ No

FAMILY HISTORY Acct #:_____

Condition	Relationship to Patient
☐ Alzheimer's	
☐ Anesthesia Problems	
☐ Asthma	
☐ Cancer (type:_____)	
☐ Diabetes	
☐ Glaucoma	
☐ Heart Attack	
☐ Heart Disease	
☐ High Cholesterol	
☐ Hypertension	
☐ Kidney Stones	
☐ Mental Illness	
☐ Osteoarthritis	
☐ Rheumatoid Arthritis	
☐ Sickle Cell Anemia	
☐ Stroke	
☐ Seizures	
☐ Thyroid disorder	
☐ Other:_____	

CURRENT MEDICATIONS

Please list all current medications, supplements, and vitamins you currently take. Please include the dosage/strength and frequency of your medications.

Medication/Supplement/Vitamins	Dosage or Strength	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		

Please indicate which (if any) of the following blood thinners you are taking: Acct #:_____

☐ Not on blood thinners.

☐ Aspirin	☐ Effient	☐ Plavix	☐ Ticlid
☐ Aggrenox	☐ Eliquis	☐ Pletal	☐ Warfarin
☐ Coumadin	☐ Lovenox	☐ Pradaxa	☐ Xarelto
			☐ Other:_____

DRUG ALLERGIES

☐ No known drug allergies.

Medication Name	Type of Reaction
1.	
2.	
3.	
4.	
5.	

Are you allergic to iodine or contrast dye? ☐ Yes ☐ No Type of Reaction: _____

Are you allergic to shellfish or seafood? ☐ Yes ☐ No Type of Reaction: _____

Are you allergic to latex? ☐ Yes ☐ No Type of Reaction: _____

Are you allergic to metal? ☐ Yes ☐ No Type of Reaction: _____

If yes, have you had confirmed metal allergy testing? ☐ Yes ☐ No

How were you referred to our office?

☐ Referring Physician ☐ Employer ☐ Insurance Co.

☐ Family Member/Friend ☐ Website Name: _____ ☐ Other (please specify): _____

Financial Policy

Thank you for choosing UNC Health Cary Orthopaedic and Sports Medicine Specialists for your orthopaedic care needs. We are committed to providing you with the highest quality care in a transparent and cost-effective manner. We feel that a clear understanding of our financial policies will help foster this goal and maintain the quality of customer service we strive to provide our patients. Please do not hesitate to contact us if you have questions regarding our policies.

Insurance Card: As a courtesy to our patients, we will gladly file your insurance. In order to do this, we require a current copy of the patient's insurance card at each visit. We will scan your card(s) and photo ID for our files**. If you do not have proof of insurance at the time of your visit and wish to be seen by one of our providers, you will be required to pay the estimated charges your visit at the time you check in/register.**

Co-Payments/Co-Insurance /Deductibles: If you are having surgery or are scheduled for an in-office procedure, your insurance benefits will be verified prior to the procedure and an estimate of the cost will be provided to you. **This estimate does not include charges for anesthesia, facility, facility related charges, DME or hardware, or rehabilitation services.** You will be billed separately for these service by the facility or rendering provider**.** You will be **required** to pay the estimated balance for service rendered at the time of check-in/registration on each visit. We gladly accept **Visa, Mastercard, Discover** and **American Express, checks** and **cash** as a form of payment.

Insurance Claims: Your insurance benefits are a contract between you and your insurance company, but we will be happy to file your insurance for you. In order to properly bill your insurance company for the services we provide, we require that you disclose all insurance information including primary, secondary, and tertiary insurances, as well as any recent changes in your insurance information or status on each visit. As noted above, **if you do not have proof of active insurance at the time of your visit but wish to be seen by one of our providers, you will be required to pay out of pocket for any expenses incurred on that visit.** Although we will always provide a good faith estimate of the amount that your insurance may or may not cover, it is the insurance company that makes the final determination regarding your eligibility and benefits for service. We **do not** file third party insurance, such as automobile or liability insurance.

Referrals/Authorizations: If your insurance company requires a referral and/or preauthorization for any services we provide, please inquire about how to obtain this approval from our business office staff or our billing department, and we will be happy to guide you. **Lack of required authorization may result in a denial of payment by your insurance company, and the balance would become the patient's personal responsibility.**

Self-Pay Accounts: Self-pay accounts are patients without insurance coverage, patients covered by an insurance plan UNC Health Cary Orthopaedic and Sports Medicine Specialists does not participate with, patients who chose not to file their insurance, or patients without an active insurance card on file with us. You will be **required** to pay for your visit in full at the time of service when you check-in/register. As an added convenience, we gladly accept **Visa, Mastercard, Discover** and **American Express, checks** and **cash** as a form of payment.

Missed or Cancelled Appointments: In order to allow us the opportunity to provide an appointment to all patients who need or requests one, UNC Health Cary Orthopaedic and Sports Medicine Specialists will add a $100.00 charge for any no-show or cancelled appointment for an in-office procedure, MRI, or surgery without a 24 hour notice.

Divorced/Separated Parents of Minor Children: The responsibility for payment of services rendered to any dependent children, whose parents are legally separated or divorced, lies with the parent or guardian who physically brings the minor to the appointment. That individual will be required to pay all copay, coinsurance and deductible responsibility at the time the patient is seen.

Acct #:_____

Returned Checks: UNC Health Cary Orthopaedic and Sports Medicine Specialists will charge a patients account $25.00 for any returned check by your bank. This will be payable by cash or money order only. This fee will be in addition to any previously accrued expense. Additionally, checks will no longer be accepted as a form of payment on your account.

Collection Accounts: UNC Health Cary Orthopaedic and Sports Medicine Specialists makes every attempt to avoid turning a patient's account over to an outside collection agency. In the event the account is sent to outside collections, the person who is financially responsible for the account will be responsible for all collection costs, including attorney fees and court cost. We recognize that issues occur that may make it difficult to pay account balances. However, patient accounts that go to an outside collection agency, more than one time, **will no longer be allowed to schedule an appointment or be seen by a UNC Health Cary Orthopaedic and Sports Medicine Specialist provider.**

Bankruptcy: Any patient whose account is written off due to bankruptcy will not be allowed to continue to receive services from UNC Health Cary Orthopaedic and Sports Medicine Specialists. Upon your written permission, we will be happy to provide you or those you designate a copy of your medical records.

Account Refunds: UNC Health Cary Orthopaedic and Sports Medicine Specialists makes every attempt to provide a good faith estimate of the cost of services we provide. In the event that we over collect for these services, we are happy to provide a timely refund after all services have been properly adjudicated by your insurance company and the balance of the account has been paid in full. We write refunds checks **once** monthly as necessary.

Lost/Expired/Damaged Refund Checks: UNC Health Cary Orthopaedic and Sports Medicine Specialists will charge a $25.00 fee for all lost, expired, or damaged refund checks that have to be re-written. This fee will come out directly from the amount of the original refund check and will be re-written during the course of the monthly refund process. Cary Orthopaedic writes refunds checks **once** monthly as necessary.

Forms and Imaging Requests: UNC Health Cary Orthopaedic and Sports Medicine Specialists will charge a $35.00 per form fee for any form requested to be completed by a physician. We will charge a $5.00 fee for copies of any imaging including x-rays and MRI.

I have read and understand the UNC Health Cary Orthopaedic and Sports Medicine Specialist financial policy. I hereby authorize UNC Health Cary Orthopaedic and Sports Medicine Specialists and its providers to bill my insurance as given. I understand that I am responsible for paying the deductible, co-insurance, copay and any non-covered services as determined by my insurance company and the above financial policy.

_____

Patient/Guardian (print name)

_____ _____

Patient/Guardian (signature) **Date**

Updated 03/24/21-mlw

Acct #:_____

Late Cancellation/No-Show Policy

In order to accommodate the needs of all of our patients in a timely and convenient manner, *UNC Health Cary Orthopaedic and Sports Medicine Specialists* **requires a twenty-four hour notice (24 hour) of a cancelled or missed appointment.**

When a patient fails to notify a clinic in advance that he or she will not be arriving for a scheduled appointment, this interferes with the clinic's ability to offer this appointment to another patient. *UNC Health and Cary Orthopaedic and Sports Medicine Specialists* will charge a **$100.00 Late Cancellation/No-Show fee** for the following appointments that are cancelled or missed without twenty-four hours (24 hours) notice:

- Pre-Planned Procedures or Injections
- Pre-Planned Surgical Procedures scheduled in the facilty or office
- MRI

When a patient repeatedly cancels or arrives late for an appointment, clinic flow is disrupted, which may negatively impact other patients, providers and staff. *UNC Health Cary Orthopaedic and Sports Medicine Specialists* reserves the right to dismiss a patient from the practice if they arrive late, no-show, or fail to notify our practice within twenty-four hours (24 hours) of a missed appointment, three or more times in a twelve (12) month period.

I have read and understand the *UNC Health Cary Orthopaedic and Sports Medicine Specialists* ***Late Cancellation/No-Show Policy***. In addition, I agree to comply with this policy and pay any and all fees related to a cancellation and/or No-Show of an appointment, without twenty-four hour (24 hour) notice.

_____

Patient/Guardian (print name)

_____ _____

Patient/Guardian (signature) Date

Acct #:_____

Acknowledgement of Receipt of
Notice of Privacy Practices v06
HIM# 720s

The ***Notice of Privacy Practices*** is a complete description of my rights as a patient of University of North Carolina Health Care System ("UNC Health Care") affiliate. By signing below, I am stating I have received the UNC Health Care ***Notice of Privacy Practices.***

PATIENT SIGNATURE: _____
(or authorized representative)

PRINTED NAME: _____ DATE: _____ TIME: _____

RELATIONSHIP, if not patient: _____

GENERAL CONSENT FOR TREATMENT (PAGE 1 of 6)
HIM #129s

I understand that the University of North Carolina Health Care System (UNC Health Care) is an integrated health system made up of various entities, including (but not necessarily limited to) UNC Hospitals; Rex Hospital, Inc.; Caldwell Memorial Hospital, Incorporated; Chatham Hospital, Inc.; Henderson County Hospital Corporation d/b/a Margaret R. Pardee Memorial Hospital; the University of North Carolina at Chapel Hill, School of Medicine; Johnston Health Services Corporation; Nash Hospitals, Inc.; Nash MSO, Inc.; NHCS Physicians, Inc. ; UNC Rockingham Health Care, Inc.; Wayne Memorial Hospital, Inc. d/b/a Wayne UNC Health Care ; Wayne MRI, LLC; UNC Physicians Network, LLC; and UNC Physicians Network Group Practices, LLC (each referred to in this form as a "UNC Health Care affiliate" or collectively as "UNC Health Care affiliates"). **This consent will be effective for 1 year after the date I sign it at any UNC Health Care affiliate of which I am a patient; however, this consent will not expire for services, claims processing or collection activities for admissions or visits occurring while this consent was in effect.**

Consent for Treatment/Care
I consent to treatment and care by UNC Health Care affiliates and by their physicians and health care providers, including those who are located at sites other than the one at which I am present and who provide treatment and care through electronic communications/telemedicine. I also consent to treatment and care by physicians and health care providers who are not employees or agents of UNC Health Care affiliates but are authorized by UNC Health Care affiliates to provide treatment and care to me as a patient of the UNC Health Care affiliate. I am aware that the providers listed on Exhibit A to this consent are independent contractors of UNC Health Care affiliates, as listed, and they provide services to the UNC Health Care affiliate's patients in accordance with their professional judgment. The providers listed on Exhibit A are not employees or agents of the UNC Health Care affiliate. I understand that my treatment and care may include routine care, such as immunizations, and a variety of other medical services depending on my condition, such as laboratory testing. I can receive a list of services and care from my health care provider. I understand that my care team at UNC Health Care affiliates may include resident physicians and students or other trainees. I am aware that the practice of medicine (including surgery) is not an exact science, and no one has made any guarantees about the results of my treatments, examinations, or procedures.

Consent for Use and Release of Information
I give permission to UNC Health Care affiliates – including their treating and referring providers and other staff members – to release any information about me, my health, the health services provided to me, or payment for my health services, that may be necessary: (1) for my treatment (to health care providers or facilities that need the information for my continued care); (2) for any purposes related to payment by me or a third party for services (to determine eligibility, to process an insurance claim, for utilization and quality review, or for billing or collection purposes, as necessary to obtain payment); (3) for the health care operations of the UNC Health Care affiliate or another health care provider that has had a relationship with me (quality assessment, training programs, planning, and fundraising); or (4) as otherwise described in the Notice of Privacy Practices and as permitted by law.

For more detailed information about the way my information may be used or released, I can read UNC Health Care's *Notice of Privacy Practices.*

I give permission to UNC Health Care affiliates and their employees, agents, and contractors to take photographs or make videos or drawings of me for permissible treatment, payment, or health care operations purposes (which may include quality assessment, education, and training), as long as consistent with policies and laws that protect my rights.

Consent for Use Within UNC Health Care
I further give permission to UNC Health Care affiliates and their treating providers and other staff members to disclose to each other any of my sensitive information necessary for my treatment, including information related to behavioral and/or mental health (including records of my treatment by a facility whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of the mentally ill, developmentally disabled, or substance abusers, as defined by N.C.G.S. Chapter 122C, Articles 1 and 3), drugs and alcohol (including records of a provider that provides alcohol or drug abuse diagnosis, treatment, or referral, as defined by federal law at 42 C.F.R. Part 2), HIV/AIDS and other communicable diseases, and genetic testing.

GENERAL CONSENT FOR TREATMENT (CONTINUED) – PAGE 2 OF 6

Financial Responsibility

I understand and agree that physician charges for medical and related professional services performed or supervised by a physician will be billed separately from hospital charges. I understand that my actual charges may be different from charge estimates given to me. I also understand that an insurance company may not pay the full amount of my charges, and I may be responsible (as a patient, spouse, or the parent of a minor child) for the amount not paid. If I do not have health insurance or have not provided current or accurate insurance information, I am responsible for payment of all charges. If I have overpaid any of my accounts with a particular UNC Health Care affiliate, I agree that the overpayment may be applied to pay any outstanding charges on any of my accounts with other UNC Health Care affiliates.

I further authorize release of financial information and activity related to payment for services to:
Name of Individual: _____
Relationship to Patient: _____

Medicare/Medicaid/Insurance Certification, Assignment & Payment Request

I have been informed that Medicare will only pay for services that it determines to be reasonable and necessary under section 1862(a)(1) of the Medicare Law. I certify that the information given by me or by my authorized representative in applying for payment for my health care under the Medicare or Medicaid programs is correct. I request that payment of authorized benefits be made to the appropriate UNC Health Care affiliate on my behalf. I authorize UNC Health Care affiliates to bill directly and assign the right to all health and liability insurance benefits otherwise payable to me, and I authorize direct payment to the appropriate UNC Health Care affiliate.

Social Security Number

I have given my social security number voluntarily. UNC Health Care affiliates may use it for accurate identification, filing insurance claims, billing and collections, and compliance with federal and state laws.

Wireless Telephone Number

UNC Health Care affiliates, or their agents or representatives, may contact me by telephone at any number contained in my UNC Health Care affiliate's records, including wireless telephone numbers, for the purposes of communicating with me about my health care, servicing my account and collecting amounts due. Methods of contact may include pre-recorded or artificial voice messages and text messages, and the use of automatic dialing services. I understand that I may revoke this consent at any time by calling or writing to UNC Health Care.

Personal Property

Unless I am a resident of a skilled nursing facility, I understand that UNC Health Care affiliates do not assume responsibility for my personal belongings that I keep in my possession, and I release UNC Health Care affiliates from all liability for the loss or theft of, or damage to, such belongings.

Patient List

As a convenience to patients and visitors, UNC Health Care affiliates may keep a list of patients currently receiving services at a facility so that they may provide the location of the patient in the facility and the patient's general condition to people who ask for patients by name. Unless I have initialed below, I give permission for UNC Health Care affiliates to give my location and general condition to individuals who ask for me by name.

_____ *(initial)* I do not want to be included in UNC Health Care affiliates' patient lists. Please remove my name.

Religious Information

UNC Health Care affiliates may provide a patient list for community clergy when they request it. This list includes the name and location of the patient, the patient's general condition, and the patient's religious affiliation. Unless I have initialed below, I give permission for UNC Health Care affiliates to give my name, location, general condition, and religious affiliation to community clergy who request it.

_____ *(initial*) I do not want to be included in UNC Health Care affiliates' list provided for clergy. Please remove my name. I understand that those employed by a UNC Health Care affiliate as chaplains may still obtain this information.

Sharing Information with Family and/or Friends

As a courtesy, limited health information may be shared with family and friends under the following conditions: (1) the information is related to that individual's involvement in the patient's care or payment for care, or (2) the information is needed to notify individuals responsible for the patient's care about the patient's location, general condition or death. Unless I have initialed below, I give permission for limited health information to be shared with my family and friends under the conditions mentioned above.

_____ *(initial)* I do not want personal health information shared with family or friends.

I UNDERSTAND THAT I MAY WITHDRAW THIS CONSENT IN WRITING. MY WITHDRAWAL WILL NOT BE EFFECTIVE FOR ACTIONS ALREADY TAKEN BY ANY UNC HEALTH CARE AFFILIATE, OR IN PROGRESS.

Acct #:_____

I AUTHORIZE UNC HEALTH CARE AFFILIATES TO RELEASE ALL RECORDS REQUIRED TO ACT ON THESE REQUESTS. I HAVE READ AND UNDERSTAND THIS FORM, RECEIVED A COPY, AND I AM THE PATIENT OR

I AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS FORM.

_____ DATE: _____ TIME: _____
PATIENT SIGNATURE (or Authorized Representative)

_____

PRINTED NAME

RELATIONSHIP, if not patient: _____

GUARANTOR: If I sign below as guarantor (not as the patient, or spouse of the patient, or the parent of a minor child), I agree to pay all charges of any UNC Health Care affiliate not paid, **even if I am otherwise not legally obligated to pay**.
_____ DATE: _____ TIME: _____
GUARANTOR OF PAYMENT SIGNATURE

_____
PRINTED NAME

EXHIBIT A

Independent Contractors at UNC Health Care Affiliates

UNC Hospitals ("UNCH")
I am aware that physicians, nurse practitioners and physician assistants who provide services to UNCH patients may be independent contractors who provide services to UNC Hospitals' patients in accordance with their professional judgment. These practitioners are not employees or agents of UNC Hospitals.

Rex Hospital, Inc. ("Rex")
I am aware that the emergency room physicians, anesthesiologists, CRNAs, pathologists, psychiatrists, OB hospitalists; radiologists, and radiation oncologists, and their nurse practitioners and physician assistants, are independent contractors who provide services to Rex patients in accordance with their professional judgment. These practitioners are not employees or agents of Rex.

Caldwell Memorial Hospital, Incorporated ("Caldwell")
I am aware that some providers, including but not limited to emergency room physicians, anesthesiologists, pathologists, radiologists, and medical and radiation oncologists, and their nurse practitioners and physician assistants, are independent contractors who provide services to Caldwell patients in accordance with their professional judgment. These practitioners are not employees or agents of Caldwell.

Chatham Hospital, Inc. ("Chatham")
I am aware that the emergency room physicians, anesthesiologists, CRNAs, hospitalists, pathologists, and radiologists, and their nurse practitioners and physician assistants, are independent contractors who provide services to Chatham patients in accordance with their professional judgment. These practitioners are not employees or agents of Chatham.

Henderson County Hospital Corporation d/b/a Margaret R. Pardee Memorial Hospital ("Pardee")
I am aware that the radiologists, anesthesiologist group, radiation oncologists, and pathologists, and their nurse practitioners and physician assistants, are independent contractors who provide services to Pardee patients in accordance with their professional judgment. These practitioners are not employees or agents of Pardee.

Johnston Health Services Corporation ("Johnston")
I am aware that most physicians providing care at Johnston, and their nurse practitioners and physician assistants, are independent contractors who provide services to Johnston in accordance with their professional judgment. These practitioners are not employees or agents of Johnston.

Nash Hospitals, Inc. ("Nash")
I am aware that all the physicians who practice at Nash and may treat me, including but not limited to emergency room physicians, anesthesiologists, pathologists, radiologists, medical and radiation oncologists, EKG readers, hospitalists (including primary care hospitalists, pediatric hospitalists, neonatologists and surgicalists), bariatric surgeons, cardiologists, psychiatrists, wound care physicians, and their respective nurse practitioners and physician assistants, are independent contractors who provide services to Nash patients in accordance with their professional judgment; and I understand that these practitioners are not employees or agents of Nash, and that Nash is not liable for their actions.

Wayne Memorial Hospital, Inc. d/b/a Wayne UNC Health Care ("Wayne")
I am aware that the radiologists, pathologists, anesthesiologists, emergency room physicians, surgeons, psychiatrists, internists, nephrologists, oncologists, EKG readers, cardiologists, wound care physicians, intensivists, hospitalists and any other independent physician and their nurse practitioners and physician assistants, are independent contractors who provide services to Wayne's patients in accordance with their professional judgment. These practitioners are not employees or agents of Wayne.

Wayne MRI, LLC ("Wayne MRI")
I am aware that the radiologists at Wayne MRI are independent contractors who provide services to Wayne MRI in accordance with their professional judgment. These practitioners are not employees or agents of Wayne MRI.

UNC Rockingham Health Care, Inc. ("Rockingham")
I am aware that some providers, including but not limited to emergency room physicians, anesthesiologists, pathologists, radiologists, and medical and radiation oncologists, and their nurse practitioners and physician assistants, are independent contractors who provide services to Rockingham patients in accordance with their professional judgment. These practitioners are not employees or agents of Rockingham.

EXHIBIT B

NOTICE OF NONDISCRIMINATION

UNC Health Care and its affiliated Network Entities comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. UNC Health Care and its affiliated Network Entities do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

A. Free Aids and Services
UNC Health Care and its affiliated Network Entities:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need to receive these services, contact the individual identified below (Section C), for the Network Entity location where you are receiving services.

B. Grievances

If you believe that UNC Health Care or an affiliated Network Entity has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the following individuals (Section C), depending on where you are receiving services. You can file a grievance in person or by mail, fax, or e-mail. If you need help filing a grievance, the individual identified below, for the Network Entity location where you are receiving services, is available to help you.

C. Contacts

Network Entity	Person to Assist with Free Aids and Services	Person to Assist with Free Aids and Services
UNC Medical Center (UNC Hospitals; UNC Faculty Physicians; UNC Health Care Shared Services Pharmacy; UNC Homecare; and UNC Home Health)	Director of Patient Relations 101 Manning Drive Chapel Hill, NC 27514 Phone: (984) 974-5006 E-mail: patrel1@unchealth.unc.edu	Director of Patient Relations 101 Manning Drive Chapel Hill, NC 27514 Phone: (984) 974-5006 E-mail: patrel1@unchealth.unc.edu
Caldwell Memorial Hospital, Inc.	Patient Care Coordinator 321 Mulberry Street SW P.O. Box 1890 Lenoir, NC 28645 Phone: (828) 757-5100	Risk & Regulatory Department 321 Mulberry Street SW P.O. Box 1890 Lenoir, NC 28645 Phone: (828) 757-5555 E-mail: RiskMgtUNCCaldwell@unchealth.unc.edu
Chatham Hospital, Inc. and **Chatham Imaging Services of Pittsboro, LLC**	Interpreting Services Director 475 Progress Boulevard Siler City, NC 27344 Phone: (919) 799-4770	Director of Quality and Risk Management 475 Progress Boulevard Siler City, NC 27344 Phone: (919) 799-4015
Johnston Health Services Corp. (d/b/a **Johnston Health**)	Telephone Operator 509 N. Bright Leaf Boulevard P.O. Box 1376 Smithfield NC 27577 Phone: (919) 934-8171	Compliance Director 509 N. Bright Leaf Boulevard P.O. Box 1376 Smithfield NC 27577 Phone: 919-938-7121
Henderson County Hospital Corp. (d/b/a **Margaret R. Pardee Memorial Hospital**)	Interpreter Services 800 North Justice Street Hendersonville, NC 28791 Phone: (828) 696-4644	Civil Rights Coordinator 800 North Justice Street Hendersonville, NC 28791 Phone: (828) 698-7998
Nash Health Care Systems (Nash Hospitals, Inc.; Nash MSO, Inc.; and NHCS Physicians, Inc.)	Community Outreach/Emergency Management Coordinator 2460 Curtis Ellis Drive Rocky Mount, NC 27804 Phone: (252) 962-3461	Coordinator for Quality Support Services & Risk Management 2460 Curtis Ellis Drive Rocky Mount, NC 27804 Phone: (252) 962-8767
UNC REX Healthcare (Rex Hospital, Inc.; Rex Surgery Center of Wakefield, LLC; Rex Surgery Center of Cary, LLC; Rex Wakefield Wellness, LLC; and Rex Radiation Oncology, LLC)	Director of Patient Relations 101 Manning Drive Chapel Hill, NC 27514 Phone: (984) 974-5006 E-mail: patrel1@unchealth.unc.edu	Director of Quality Programs 4420 Lake Boone Trail Raleigh, NC 27607 Phone: (919) 784-3429
UNC Rockingham Health Care, Inc.	Administrative Supervisor 117 East Kings Highway Eden, NC 27288 Phone: (336) 520-7592 ext. 1712229	Director of Quality and Risk Management 117 East Kings Highway Eden, NC 27288 Phone: (336) 627-4212
UNC Physicians Network, LLC; and **UNC Physicians Network Group Practices, LLC**	Director of Patient Relations 101 Manning Drive Chapel Hill, NC 27514 Phone: (984) 974-5006 E-mail: patrel1@unchealth.unc.edu	Human Resources Executive 2000 Perimeter Park Drive Suite 200 Morrisville, NC 27560 Phone: (984) 215-4032 E-mail: contactuncpn@unchealth.unc.edu
Wayne Memorial Hospital, Inc. (d/b/a Wayne UNC Health Care) (Wayne MRI, LLC)	Patient Care Coordination Department 2700 Wayne Memorial Drive Goldsboro, NC 27530 Phone: (919) 731-6407	Patient Experience Department 2700 Wayne Memorial Drive Goldsboro, NC 27530 Phone: (919) 587-2273 Email: patient.experience@waynehealth.org

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; 1-800-368-1019; 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

D. Attention

- ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al:
- ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le:
- CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số:
- 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電：
- ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer:
- 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 연락처:
- ध्यान दें: यदद आप द ंदी बोलते ै ं तो आपके ललए भाषा स ायता सेवाएि ननिःशुल्क उपलब्ध ै ं। इस पर कॉल करें:
- PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa:
- LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau:
- **સુચના: જો તમે ગુજરાતી બોલતા હો, તો નન:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો**:
- ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните:
- Dè dɛ nià kɛ dyédé gbo: Ɔ jǔ ké m̀ [Bàsɔ́ɔ̀-wùdù-po-nyɔ̀] jǔ ní, nǐí, à wudu kà kò dò po-poɔ̀ bɛ́ìn m̀ gbo kpáa. Đá:
- గమనిక: మీరు తెలుగు భాషను మాట్ాడేవారు అయితే, భాష సహాయక సేవలు మీకు ఎట్ంవంట్ి ఛార్జీలు లేకుండా ఉచితంగా అందుబాట్ంలో ఉన్ాయి. ఈ నంబర కు కాల్ చేయండి:
- ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero:
- ملحوظة :إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان .اتصل برقم

UNC Medical Center
(UNC Hospitals, UNC Faculty Physicians, UNC Shared Services Center Pharmacy, UNC Homecare, and UNC Home Health):
1-984-974-5006

Caldwell Memorial Hospital:
1-828-757-5100

Chatham Hospital and Chatham Imaging Services of Pittsboro:
1-984-974-5006

UNC REX Healthcare
(Rex Hospital; Rex Surgery Center of Wakefield; Rex Surgery Center of Cary; Rex Wakefield Wellness; and Rex Radiation Oncology):
1-984-974-5006

Johnston Health:
1-919-934-8171

Margaret R. Pardee Memorial Hospital:
1-828-696-4644

Nash Health Care Systems (Nash Hospitals, Nash MSO, and NHCS Physicians):
1-252-962-8000

UNC Rockingham Health Care
1-336-520-7592 ext. 1712229

Wayne Memorial Hospital (Wayne MRI, LLC)
1-919-736-1110

UNC Physicians Network (UNCPN) and UNC Physicians Network Group Practices (UNCPN GP):
1-984-974-5006

UNC HEALTH | Cary Orthopaedics

Acct #:_____

Patient Name: _____ Date of Birth: _____

Limited Release of Information to Family/Friends

I give my permission to my physician practice that is part of the UNC Health Care System to share certain personal health information about me with the individuals listed below. These individuals will only be given information about me that is relatable to their involvement in my care or payment for my care.[i] I understand that I am not required to complete this form in order to obtain health care.

Name: _____ Phone Number: _____

Relationship: _____ Talk to this person about (*check each box that applies*):

☐ My Health Care ☐ My Bills ☐ Only these things: _____

Name: _____ Phone Number: _____

Relationship: _____ Talk to this person about (*check each box that applies*):

☐ My Health Care ☐ My Bills ☐ Only these things: _____

Name: _____ Phone Number: _____

Relationship: _____ Talk to this person about (*check each box that applies*):

☐ My Health Care ☐ My Bills ☐ Only these things: _____

If I change my mind about the people or the contact information I have listed in this form, I will tell you by calling my doctor's office or completing a new from.

_____ Date: _____

PATIENT SIGNATURE (or Authorized Representative)

PRINTED NAME & RELATIONSHIP (if not patient): _____

[i]This form is not a substitute for a health care power of attorney or other formal designation of an individual authorized to make health care decisions for you if you are not able. If an individual listed above is your guardian or agent (under a power of attorney) or is otherwise authorized by law to at on your behalf, your healthcare provider may share as much of your person health information with that person as the law permits.

This form is not considered sufficient authorization to release sensitive information such as mental health, substance abuse and infectious disease related treatment information.

This form is not a substitute for a valid HIPAA compliant written authorization when it is required to release copies of medical and billing records or information.