Morganton Internal Medicine, PA
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act (HIPAA; "Act") of 1996, revised in 2013, requires us as your health care provider to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We are required to maintain these records of your health care and to maintain confidentiality of these records.

The Act also allows us to use your information for treatment, payment, and certain health operations unless otherwise prohibited by law and without your authorization.

- Treatment: We may disclose your protected health information to you and to our staff or to other health care providers in order to get you the care you need. This includes information that may go to the pharmacy to get your prescription filled, to a diagnostic center to assist with your diagnosis, or to the hospital should you need to be admitted. If necessary to ensure that you get this care, we may also discuss the minimum necessary with friends or family members involved in your care unless you request otherwise.
- Payment: We may send information to you or to your health plan in order to receive payment for the service or item we delivered. We may discuss the minimum necessary with friends or family members involved in your payment unless you request otherwise.
- Health operations: We are allowed to use or disclose your protected health information to train new health care workers, to evaluate the health care delivered, to improve our business development, or for other internal needs.
- We are required to disclose information as required by law, such as public health regulations, health care oversight activities, certain law suits and law enforcement.

Certain ways that your protected health information could be used disclosed require an authorization from you: disclosure of psychotherapy notes, use or disclosure of your information for marketing, disclosures or uses that constitute a sale of protected health information, and any uses or disclosures not described in this NPP. We cannot disclose your protected health information to your employer or to your school without your authorization unless required by law. You will receive a copy of your authorization and may revoke the authorization in writing. We will honor that revocation beginning the date we receive the written signed revocation.

You have several rights concerning your protected health information. When you wish to use one of these rights, please inform our office so that we may give you the correct form for documenting your request.

- You have the right to access your records and/or to receive a copy of your records, with the exception of psychotherapy notes. Your request must be in writing, and we must verify your identity before allowing the requested access. We are required to allow the access or provide the copy within 30 days of your request. We may provide the copy to you or to your designee in an electronic format acceptable to you or as a hard copy. We may charge you our cost for making and providing the copy. If your request is denied, you may request a review of this denial by a licensed health care provider.
- You have the right to request restrictions on how your protected health information is used for treatment, payment, and health operations. For example, you may request that a certain friend or family member not have access to this information. We are not required to agree to this request, but if we agree to your request, we are obligated to fulfill the request, except in an emergency where this restriction might interfere with your care. We may terminate these restrictions if necessary to fulfill treatment and payment.

- We are required to grant your request for restriction if the requested restriction applies only to information that would be submitted to a health plan for payment for a health care service or item for which you have paid in full out-of-pocket, and if the restriction is not otherwise forbidden by law. For example, we are required to submit information to federal health plans and managed care organizations even if you request a restriction. We must have your restriction documented prior to initiating the service. Some exceptions may apply, so ask for a form to request the restriction and to get additional information. We are not required to inform other covered entities of this request, but we are not allowed to use or disclose information that has been restricted to business associates that may disclose the information to the health plan.
- You have the right to request confidential communications. For example, you may prefer that we call your cell phone number rather than your home phone. These requests must be in writing, may be revoked in writing, and must give us an effective means of communication for us to comply. If the alternate means of communications incurs additional cost, that cost will be passed on to you.
- Your medical records are legal documents that provide crucial information regarding your care. You have the right to request an amendment to your medical records, but you must make this request in writing and understand that we are not required to grant this request.
- You have the right to an accounting of disclosures. This will tell you how we have used or disclosed your protected health information. We are required to inform you of a breach that may have affected your protected health information.
- You have the right to receive a copy of this notice, either electronic or paper or both.
- You have the right to opt out of fund raising communications.

If you have any questions about our privacy practices, please contact our Privacy Officer at the number below.

You have the right to file a complaint with us or with the Office for Civil Rights. We will not discriminate or retaliate in any way for this action. To file a complaint, please contact the applicable party:

Privacy Officer: Dedra Pasco

Phone number: __828-433-0225_____

Fax number: ___828-437-0227_____

Office for Civil Rights
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

We are required to abide by the policies stated in this Notice of Privacy Practices, which became

effective on (date)_08/23/2022_____.

Morganton Internal Medicine
DIPLOMATS AMERICAN BOARD OF INTERNAL MEDICINE
607 E. PARKER ROAD
MORGANTON, NORTH CAROLINA 28655
TELEPHONE 828-433-0225
FAX 828-437-0227

DAVID S. ABERNATHY, M.D.

MICHAEL S. STUTESMAN, M.D.

Dear New Patient:

Welcome to our practice. We are very pleased that you have selected us for your medical care. Thank you for choosing us. We look forward to partnering with you to address your health concerns and preventative care. Enclosed are forms for you to fill out in advance of your appointment to assist our office staff and doctors in making sure that we have all the information necessary to provide you with quality care and treatment. Please fill out all the forms completely in black ink. If you have any questions or problems filling out the forms, do not hesitate to call so that we may assist you. **When you have completed your forms, please return them to our office prior to your appointment.** This will allow our doctors to review your medical history prior to your appointment and will allow our staff to have your chart prepared in advance in order to help prevent delays in seeing the doctor.

If you have been treated by a physician or hospital for the reason you are visiting us, then you may want to request copies of pertinent medical records in advance of your appointment. You may either have them give the records to you directly, or they can fax them to us at fax number 828-437-0227. Enclosed are medical records release forms to help you with this process.

Our doctor's try very hard to stay on time with their patients, but sometimes medical emergencies do occur which can cause them to run behind. You can do your part by showing up on time for your appointment with all the paper work completed and sent back to us prior to your appointment. We ask that you arrive at least 30 minutes before your scheduled time with the doctor. This allows time for our certified medical assistants to personalize your chart by reviewing your health history and current health needs with you.

Please bring all of your medications including any over the counter medicines as well as vitamins with you to your appointment. If you have advance healthcare directives such as a Living Will, Health Care Power of Attorney, MOST form, and/or Do Not Resuscitate (DNR) forms, please bring your copy with you and allow us to scan into your chart. If you have medical implant cards please provide them to our staff to put a copy in your record.

We will call two days before your appointment to confirm your visit. If for any reason you see that you need to cancel, please give us 24 hours' notice.

Once again, welcome to our practice. We look forward to providing you with quality care.

Thank you from The Staff of Morganton Internal Medicine

Morganton Internal Medicine
Practice Information

Office Hours:
Monday thru Friday 8:00 a.m. to 5:00 p.m.

Location:
607 East Parker Road, Morganton, NC 28655
From I-40: Take exit 105 onto South Sterling Street towards Blue Ridge Health Care Atrium Hospital. At the second stop light turn right onto East Parker Road. You will drive approximately one mile and our office on the left.

Insurance:
Health care insurance is intended to cover some, but not all, of the cost of your treatment. Most plans include co-insurance, copay, and deductible and other expenses which must be paid by the patient.
If you have insurance, please bring your plan information with you to assure that you receive the maximum benefits to which you are entitled. If this is not received within 6 months of service no claim will be filed on your behalf.
Our office files Medicare, Medicare Advantage, Medicaid, Aetna, BCBSNC, Humana, MedCost, Primary Physician Care, State Health Plan, United Healthcare, Direct Net and Teal Premier.
If you have questions regarding your coverage, contact your insurance plan. If you have questions relating to services here, please ask the Insurance staff for assistance.

Fee & Payments:
We make every effort to keep down the cost of your medical care. You can help by paying for treatment at the time of your visit. If your treatment program requires several visits, you will be given an estimate and asked to make financial arrangements with a member of our business staff. We accept MasterCard and VISA, Debit cards and Checks. There will be a fee of $45.00 for all returned checks.

Emergency Care:
In the event of a severe emergency, go immediately to the emergency room of the nearest hospital and ask them to contact your doctor.
If the situation is not that severe and arises while the office is closed, telephone 828-580-5000 and the answering service will promptly forward your message to the doctor on call. You will receive a response as quickly as possible.
If an urgent situation arises while the office is open, call the office and the doctor will be in touch with you either directly or through office personnel giving you instructions.

Telephone Calls:
We encourage you to call with questions you may have concerning your health care problems; however, it would be unfair to other patients if the doctor were to disrupt treatment to answer every phone call. Our staff is trained to answer most questions. If your call requires that the doctor speak with you, please leave a message and the doctor will return your call at the earliest opportunity.

Prescriptions and Renewals:
All prescriptions and authorizations for renewals should be requested at your doctor visit and other times during normal office hours.

MORGANTON INTERNAL MEDICINE, P.A.

DIPLOMATS AMERICAN BOARD OF INTERNAL MEDICINE
607 East Parker Road
Morganton, NC 28655
828-433-0225
OFFICE HOURS BY APPOINTMENT

DAVID S. ABERNATHY, MD MICHAEL S. STUTESMAN, MD

Dear_____,

Welcome to our practice. We are pleased you have chosen Morganton Internal Medicine for your health care. Your scheduled appointment with Dr._____ is:

_____, _____, _____, _____ at_____AM/PM.
Day Month Date Year

For visit to be filed with insurance your Insurance Cards have to be presented on arrival. Bring a Photo ID and bring ALL your medications.

In order to better serve you, please take time to complete the following information and return to us prior to your appointment.

NAME_____
LAST FIRST MI MAIDEN

ADDRESS:_____

CITY_____STATE_____ZIP_____

Email Address:_____Preferred Pharmacy:_____

Home Phone:_____ Work Phone:_____ext_____

Cell Phone:_____ Race:_____ Are you Latino/Hispanic? Y or N

Birthdate:_____/_____/_____ Social Security Number:_____-_____-_____

Employer:_____Job Title_____

_____Single _____Married _____Divorced _____Widowed _____Separated

Spouse Name:_____ Spouse Work Phone:_____

Spouse Cell:_____

Person to contact in case of emergency (other than spouse):

Name:_____Phone:_____

Relationship:_____Cell: _____

Last Medical Doctors Name:_____

Insurance Primary:_____ Policy ID#_____

Policy Holder:_____ Employer:_____

Insurance Secondary:_____ Policy ID#_____

Policy Holder:_____ Employer:_____

HOW DID YOU HEAR ABOUT MORGANTON INTERNAL MEDICINE?

1. NEWSPAPER_____ 2.FRIEND_____ 3.RELATIVE_____ 4. PHONE BOOK_____
5. PHYSICIAN_____ 6. INTERNET_____ 7. OTHER_____

CONTINUED ON BACK

MEDICAL INFORMATION

Present Medication	Dosage	Present Medication	Dosage

DRUG ALLERGIES

MEDICAL HISTORY

Date	Accidents/Hospitalizations/Operations	Where	Physician

FAMILY HISTORY

	Living or Expired	Illnesses or Cause of Death
Father		
Mother		
Brother(s)		
Sister(s)		
Maternal Grandparents		
Paternal Grandparents		

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS INFORMATION. IF YOU HAVE ANY QUESTIONS CALL OUR OFFICE 8:30-5:00 MONDAY-FRIDAY.

WE LOOK FORWARD TO MEETING YOU.

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DAVID S. ABERNATHY, M.D.

MICHAEL S. STUTESMAN, M.D.

FINANCIAL POLICY

We are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policies as an essential element of your care and treatment. We recognize that payment for health care services has become more complex over the past few years. Ensuring proper payment on your account is a joint responsibility between the patient and the provider. Therefore, we would like to briefly outline your role as patient and our role as provider in this process.

YOUR ROLE

- We rely on you to provide current and complete insurance information. Please inform us of any and all insurance coverage that you have. This ensures prompt billing to your carrier and helps avoid unauthorized services that may become your financial responsibility.
- You are responsible for all charges. As you know, not all services are covered by insurance plans, so you should check in advance to determine if your office visit and other services will be covered. We accept cash, check, Mastercard and Visa.
- Many insurance plans require that the patient pay some portion of the bill at the time of service in the form of copayments or deductibles.
- In most cases, we will mail a monthly statement to you so that you are aware of any payments made to us by your insurance carrier. Your carrier may also provide you with an Explanation of Benefits Statement. If your claim is not paid within 60 days, we ask that you call your insurance carrier to assist with settlement of your account.
- Our statements are sent the last business day of each month. All balances are due in full within 30 days of the statement date. If you cannot pay the balance in full within 30 days, please contact our office to discuss your account.
- Your account becomes delinquent if payment is not received within 30 days after receipt of statement with patient due balance or if you have not made payment arrangements. We will mail you a letter indicating a problem with your account. If payment is not received within 14 days of reminder notice, a contact by phone will be attempted. Failure to meet your financial obligation may result in reporting you to the Credit Bureau. An additional collection percentage will be added to your balance if the account is turned over to a collection agency. You may in addition be terminated as a patient from Morganton Internal Medicine.
- You are responsible for obtaining any necessary referrals from your primary care physician and prior approval (often called "precertification") before certain procedures, tests and surgeries, if required by your insurance carrier.

OUR ROLE

- We participate in insurance plans including point-of-service plans (POSs), health maintenance organizations (HMOs) and preferred provider organizations (PPOs). We also participate in government plans such as Medicare, Medicaid, and workers' compensation.

- ✦ Our staff will ensure your insurance carrier information is properly recorded when you present your current insurance identification card. We will ask you for your insurance cards at your visit and subsequent visits if necessary.
- ✦ We provide our patients with the service of preparing and filing insurance claims forms following any office visit, hospitalization or special procedure.
- ✦ We will work with you to obtain pre-authorization or precertification for office visits, procedures, tests and surgeries.
- ✦ If an overpayment is made by you on the account, a refund will be issued upon request.
- ✦ There is an administrative fee of $5.00 for medical records requested by a patient or from another medical office on the patients behalf. There is a minimum fee of $10.00 per page (front and back is 1 page) for forms completion.
- ✦ For checks returned for insufficient funds on the second offense you will be charged $45.00 and your account will be placed on cash only basis.

IN CLOSING

Our efforts are intended to assist the physician in delivering outstanding health care and to assist you in hassle free claims processing. We appreciate your willingness to assist us in the process, and thank you for choosing us as your health care provider.

ACKNOWLEDGEMENT

By my signature, I indicate that I have read this policy, understand its content and agree to its provisions.

Signature:_____Date:_____

Name (Please Print):_____

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PATIENT ACKNOWLEDGMENT AND CONSENT

For New Patients Only

I have been given a copy of Morganton Internal Medicine's Notice of Privacy Practices, version effective September 23, 2013. I consent to the uses and disclosures of my health information as outlined in the Notice.

_____ _____
Signature of Patient or Representative Date

_____
Print Name

_____
Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of Patient: _____

_____

_____

FOR MORGANTON INTERNAL MEDICINE USE ONLY

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain acknowledgment and the reason you could not obtain it:

_____

_____

_____

Morganton Internal Medicine

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DAVID S. ABERNATHY, M.D.

MICHAEL S. STUTESMAN, M.D.

PERMISSION TO RELEASE MEDICAL/FINANCIAL INFORMATION

I hereby authorize the Providers of Morganton Internal Medicine to release all information acquired in the course of my examination and/or treatment for the purpose of filing an insurance claim or obtaining health/life insurance. I authorize the use of this signature on all insurance submissions whether manual or electronic.

Once the Provider has obtained the patient's one-time authorization he may submit any later insurance claims, on either assigned or unassigned basis, without obtaining any additional signatures of the patient. In submitting claims, he/she should indicate in the patient's signature space: "Signature on file".

I authorize payment of medical benefits to Providers of Morganton Internal Medicine for services described on submitted claims.

_____ _____

PATIENT SIGNATURE DATE

_____

WITNESS

Morganton Internal Medicine may call and leave a message on my answering machine /voice mail if I am not available.

Please check one: ☐ YES ☐ NO

I authorize Morganton Internal Medicine to discuss my personal health information with the persons and/or facilities I have listed below.

_____ _____

Name Telephone Name Telephone

_____ _____

Name Telephone Name Telephone

In case of emergency please notify: _____

Name Telephone

_____ _____

PATIENT SIGNATURE DATE

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DAVID S. ABERNATHY, M.D.

MICHAEL S. STUTESMAN, M.D.

Consent for Release of Medical Information – New Patient

I hereby authorize the Practice, or any of its employees, staff or agents, to use and disclose health information From the medical records of:

Patient Name: _____

Address: _____

Date of Birth: _____ Last four of SS#: _____

Release Information from:

_____

Phone: _____

Fax: _____

Send Information To:

Morganton Internal Medicine, PA

Phone: 828-433-0225_____

Fax: 828-475-1215_____

Information to be released:

- 1 year of progress notes
- Most recent Comprehensive Physical Exam
- Most recent History and Physical and Discharge Summary from hospitalization if applicable
- 1 year of labs = including most recent HGB A1C, Lipid Panel, Urine Micro Albumin, Hepatitis C Screening, PSA (male)
- All immunization records
- All radiology studies
- All heart related studies
- Any Endoscopic studies including pathologies
- Most recent Mammogram (female)
- Most recent Pap Smear (female)
- Any Colon Screening in the past 10 years for example: Colonoscopy including pathology, Cologard, FIT Test, FOBT x3
- Most recent Diabetic Eye Examination

This consent permits the practice to use and disclose my health information to carry out treatment, payment, or health care operations. Additional information regarding the uses and disclosures of health information is described in the practice's "notice of privacy practices." A patient has the right to review the "notice" prior to signing this consent. A patient has the right to request restrictions uses and disclosures of health information for treatment, payment, and health care operations purposes. However, the practice is not required to agree to a patients request for restrictions. This consent to release confidential information may be revoked by me in writing, at any time, except to the extent that action has already been taken. No further confidential information will be released without the execution of an additional written statement of authorization. I understand that these records are protected under federal and state law and cannot be disclosed without my consent unless otherwise provided by law. Having read the above information, I hereby release, hold harmless and agree not to sue the practice, its employees, staff and agents, in connection with the disclosure of information set forth relating to these medical records.

This signed release will expire in 90 days from the date it was signed.

Patient Signature: _____ Date: _____

Printed Patient Name: _____

Signature of Legally Authorized Person: _____

MORGANTON INTERNAL MEDICINE
607 East Parker Road
Morganton, NC 28655
828-433-0225
David S. Abernathy, MD 828-437-0227 Fax Michael S. Stutesman, MD

Consent for Release of Medical Information

I hereby authorize the Practice, or any of its employees, staff or agents, to use and disclose health information from the medical record(s) of:

PATIENT
NAME:_____

ADDRESS:_____
(Street) (City) (State) (Zip Code)

DATE OF BIRTH:_____ MEDICAL RECORDS #:_____

Release Information from:_____
(Name of individual or organization)
_____
(Street or POB) (City, State, Zip)
Send Information to:_____
(Name of individual or organization)
_____
(Street or POB) (City, State, Zip)

Initial all that apply.
I consent to have all the medical information regarding my treatment or hospitalization from my:
_____ General hospitalization or out patient care
_____ Drug and alcohol treatment care
_____ Infection with human immunodeficiency virus (HIV) acquired immunodeficiency syndrome (AIDS)*
_____ Emergency room visit
_____ Psychiatric care
*REQUIRES SPECIAL CONSENT

I am requesting the following information to be released:
_____ Records from Date_____ to (Date)_____
_____ Entire Medical Record
_____ Records Pertaining to_____
I permit this confidential information to be released for the following purpose:
_____ Continuing Medical Treatment _____ Litigation for Review
_____ Insurance: Company Name_____
_____ Other: Specify Reason:_____

This consent permits the practice to use and disclose my health information to carry out treatment, payment or health care operations. Additional information regarding the uses and disclosures of health information is described in the practice's "notice of privacy practices." A patient has the right to review the "notice" prior to signing this consent. A patient has the right to request restrictions uses and disclosures of health information for treatment, payment, and health care operations purposes. However, the practice is not required to agree to a patient's request for restrictions. This consent to release confidential information may be revoked by me in writing, at any time, except to the extent that action has already been taken. No further confidential information will be released without the execution of an additional written statement of authorization. I understand that these records are protected under federal and state law and cannot be disclosed without my consent unless otherwise provided by law. Having read the above information, I hereby RELEASE, HOLD HARMLESS AND AGREE NOT TO SUE the Practice, its employees, staff and agents, in connection with the disclosure of information set forth relating to these medical records.

_____(Print Patient's Name)

_____(Signature of Patient) Date:_____

_____(Signature of Legally Authorized Person)