Tate Clinic

Thank you for choosing Tate Clinic as your healthcare provider. We look forward to seeing you at your appointment.

This new patient information packet includes directions to our office and contact information for your records. Also enclosed is the paperwork that you will need for your upcoming appointment. Please complete the paperwork enclosed and bring it to your appointment. Our Billing & Insurance Information, Notice of Privacy Practices and Patient Bill of Rights & Responsibilities are available online at *unchealthappalachian.org*.

For more than 100 years, three generations of Tate physicians spent their lives taking care of their beloved community and making the Tate family name synonymous with healthcare in Avery County. The Tate Legacy began in 1910, before Avery County was even a county, Dr. William C. Tate took the post of Banner Elk's physician. His small cottage hospital grew into Grace Hospital, which officially opened in 1924. He was joined there in 1947 by his son, Lawson. In 1961, the original Charles A. Cannon Jr. Memorial Hospital opened on the Elk River just outside of Banner Elk with Dr. Lawson Tate as the medical director. In 1968 Lawson Tate opened his own private practice, Tate Clinic. His son, Dr. William C. "Bill" Tate, II, joined the practice in 1977. Dr. Haizlip joined Tate Clinic in 1998 and continues to honor the original mission to provide local state of the art care to the people of Avery County.

Services include general surgery, gall bladder, hernia, breast, thyroid, skin cancer removal, colon resection and endoscopies. The Tate Clinic also maintains relationships with specialist and tertiary care centers so that more complex care can be coordinated. We look forward to continuing to serve "the mountain people" – whether you have been here for generations, just joined our community or are simply enjoying a respite from some other community.

_____

has an appointment with

_____

☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs.

_____date _____a.m./p.m.

To reschedule your appointment, please call (828) 737-7917.

Contact Us

Phone & Fax
Phone: (828) 737-7917
Fax: (828) 737-6869

Hours
Monday - Thursday: 8:00 a.m. - 5:00 p.m.

Location
436 Hospital Drive, Suite 200
Linville, NC 28646
Sloop Medical Office Plaza

New Patient Checklist

For your first appointment, please arrive 15 minutes early and bring the following:

☐ Insurance Card
☐ Pharmacy Information
☐ Medical Records
☐ Payment
☐ Current Medications/Prescription Bottles
☐ Questions for doctor
☐ Photo ID
☐ Completed forms from this packet

UNC HEALTH® Appalachian

unchealthappalachian.org

HDF9219 01/24/25

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Patient Name _____
Date of Birth _____
MRN _____
CSN _____
Please Fill in or Affix a Patient Label

Patient Registration Form (ARMA) **Form #11332**

Patient Name: First M/I Last

Date of Birth: ____/____/____ **Gender:** ☐Male ☐Female **Social Security #:** _____-_____-_____

Marital Status: ☐Married ☐Single ☐Divorced ☐ Separated ☐Widowed ☐ Life Partner

Mailing Address: Street-

City- State- Zip Code-

Primary Phone #: _____ ☐ **Cell** ☐ **Home**

Secondary Phone #: _____ ☐ **Cell** ☐ **Home**

Work Phone #: _____ **Employer/Occupation:** _____

E-mail: _____

Emergency Contact: _____ **Relationship to patient:** _____ **Ph #:** _____

I consent to Appalachian Regional Medical Associates ("ARMA") or its representatives: ☐ calling my phone and leaving a message ☐ texting me (message and data rates may apply) ☐ e-mailing me about balances due, financial assistance, appointments, pre-registration, lab results, and other healthcare information. Methods of contact may include pre-recorded voice messages and the use of automatic dialing services.

What is your ethnicity? ☐Hispanic or Latino ☐ Not Hispanic or Latino

Select one or more races to indicate what you consider yourself to be: ☐Asian ☐ White
☐ American Indian or Alaskan Native ☐ Black or African American
☐Native Hawaiian or other Pacific Islander ☐ Other: _____

Preferred language? ☐ English ☐ Spanish ☐Other: _____

How did you hear about us?
☐ Billboards ☐Doctor ☐Friends/Family ☐Magazine ☐Newspaper ☐Social Media ☐Radio ☐TV
☐ARHS Website ☐Other _____

If patient is a minor please print Guardian Name:
First: _____ M/I: _____ Last: _____

If patient has a guarantor (someone else responsible for the bill) please provider information below:

Patient's relationship to Guarantor: _____

Guarantor's Name: First: _____M/I:_____Last:_____

Mailing Address: Street-_____

City-_____State-_____ Zip-_____

Date of Birth: ____/____/_____ Social Security #: _____-_____-_____ Phone #: _____

Employer: _____ Employer Phone #: _____

Signature of Patient/ Legal Representative ▶	Date: Time:
Name of Patient/ Legal Representative *(Please Print)* ▶	Relationship of Legal Representative ▶

UNC HEALTH® Appalachian

Patient Name _____
Date of Birth _____
MRN _____
CSN _____
Please Fill in or Affix a Patient Label

Patient Information (Adult)-ARMA
Form #11580

Date: _____ ☐ **Male** ☐ **Female** **Date of Birth:** ____/____/_____
Name: First _____ Middle _____ Last _____

Address: _____ **City/State/Zip:** _____

Home Phone: _____ **Work Phone:** _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Education Level: _____ **Occupation:** _____

Employer: _____

Reason for Today's Visit:

Medical History

Medications:

1. Non-Prescription - ☑ any taken regularly

☐ Vitamins ☐ Aspirin
☐ Laxatives ☐ Antacids
☐ Decongestants ☐ Tylenol
☐ Other:

_____

2. Prescription – (including Birth Control Pills)

Medication	Dosage	# Times/Day

Immunizations: (☑ Any Recived)

☐ Measles ☐ German Measles
☐ Mumps ☐ Smallpox
☐ Hemophilus ☐ Pneumonia
☐ Hepatitis ☐ Influenza
☐ TB Skin Test: _____ Pos:_____ Neg: _____

☐ Tetanus Series (Dates): _____
_____

Allergies: (☑ Any You Are Allergic To)

☐ Animals ☐ Demerol ☐ Penicillin
☐ Aspirin ☐ Grasses ☐ Pollens
☐ Codeine ☐ Insect Bites ☐ Sulfa

Based on answer above:
Which Antibiotics? _____
Which Foods? _____
☐ Other: _____
What reaction? _____
☐ No Known Allergies

Habits:

Do you use tobacco? ☐ Yes ☐ No
☐ Chew ☐ Smoke

If yes, what kind? _____
If yes. How much? _____

Do you drink alcohol?	☐ Yes	☐ No
Do you use drugs?	☐ Yes	☐ No
Do you drink caffeinated beverages?	☐ Yes	☐ No
Do you wear your seat belt?	☐ Yes	☐ No
Do you wear a helmet when biking?	☐ Yes	☐ No
Do you wear sunscreen/sunglasses?	☐ Yes	☐ No
Do you sleep well?	☐ Yes	☐ No
Do you eat well?	☐ Yes	☐ No
Do you exercise regularly?	☐ Yes	☐ No
Do you examine breasts/ testes monthly?	☐ Yes	☐ No
Have you used Narcotics or additive drugs?	☐ Yes	☐ No

Types: _____
_____

In your home do you have:

Smoke detectors?	☐ Yes	☐ No
Carbon monoxide detectors?	☐ Yes	☐ No

Have you been exposed to chemicals, toxins, poisons, fumes, smoke or radioactive materials at home or work?
☐ Yes ☐ No How often? _____
Types: _____

Have you experienced any of the following?

☐ Marriage difficulties ☐ Job difficulties
☐ Sexual difficulties ☐ Sexual attack
☐ Nervous breakdown ☐ Sleep difficulties
☐ Emotional problems ☐ Depressions

How many people live in your Home? _____

UNC HEALTH®

Patient Label Here

GENERAL CONSENT FOR TREATMENT (PAGE 1 of 2)
HIM #129s

I understand that the University of North Carolina Health Care System (UNC Health) is an integrated health system made up of various entities as reflected at www.unchealthcare.org/documentapplicability (each referred to in this form as a "UNC Health affiliate" or collectively as "UNC Health affiliates"). **This consent will be effective for 1 year after the date I sign it at any UNC Health 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 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 affiliates (including but not limited to physicians and providers in the specialties of emergency medicine, anesthesia, surgery, pathology, psychiatry, obstetrics and gynecology, radiology, oncology, cardiology, neurology, pediatrics and internal medicine) but are authorized by UNC Health affiliates to provide treatment and care to me as a patient of the UNC Health affiliate, and who provide services to the UNC Health affiliates' patients in accordance with their professional judgment (collectively, "Independent Providers"). 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 that I have received from UNC Health affiliates. I understand that my care team at UNC Health 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 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 as permitted by law. For more detailed information about the way my information may be used or released, I can read UNC Health's *Notice of Privacy Practices*.

I give permission to UNC Health affiliates and their employees, agents, and contractors to take photographs or make videos of me for permissible treatment, payment, health care operations, education and for research purposes where either I have given consent or an Institutional Review Board has approved as long as such recordings are consistent with policies and laws that protect my rights.

Consent for Use Within UNC Health

I further give permission to UNC Health 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.

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, guardian, 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 affiliate, I agree that the overpayment may be applied to pay any outstanding charges on any of my accounts with other UNC Health affiliates. I designate UNC Health as my authorized representative with respect to any health or liability insurance policy or any group health plan, fund or program applicable to me, and I authorize UNC Health to exercise on my behalf any grievance, claim or appeal rights, including external review rights, I may have under any such health or liability insurance policy or group health plan, fund or program.

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 affiliate on my behalf. I authorize UNC Health 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 affiliate.

Social Security Number

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

Wireless Telephone Number and Electronic Mail

UNC Health affiliates, Independent Providers (as defined above), and/or any of their respective agents, representatives, or business associates (including their billing service providers or debt collectors), may contact me by electronic mail or telephone (including phone calls, prerecorded messages using automated technology, or text messages) at any electronic mail address or number contained in my UNC Health affiliate's or my Independent Provider's records, including wireless telephone numbers, for the purposes of communicating with me about my health care, requesting information about patient satisfaction, servicing my account, and/or collecting amounts due. I also understand that UNC physician researchers or members of their research team may also contact me via phone or electronic mail to determine my interest in participating in human subjects research. I consent to receive electronic mail, text messages, phone calls, and prerecorded messages using automated technology from UNC Health Care affiliates, Independent Providers, and/or any of their respective agents, representatives or business associates, including their billing service providers or debt collectors. .I understand that consent to receive electronic mail, text messages, phone calls, and prerecorded messages using automated technology is not required to receive health care services. I understand that if I wish to revoke consent to receive communications from UNC Health affiliates via phone calls, text messages, prerecorded messages using automated technology, or electronic mail, I may do so by following the instructions in the communication regarding opt-out, if any, or by calling UNC Health Customer Service at (888) 996-2767. If I wish to revoke consent to receive communications from an Independent Provider via phone calls, text messages, prerecorded messages using automated technology, or electronic mail, I may do so by following the instructions in the communication regarding opt-out, if any, or by contacting the Independent Provider directly.

Personal Property

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

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.

I AUTHORIZE UNC HEALTH CARE AFFILIATES TO RELEASE ALL RECORDS REQUIRED TO ACT ON THESE REQUESTS. I HAVE READ AND UNDERSTAND THIS FORM, BEEN OFFERED 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 OF PAYMENT: This line may be signed by someone who wishes to agree to be responsible for payment *other than*: 1) the patient, 2) the patient's spouse, or 3) a minor patient's parent.

By signing as guarantor below, 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

UNC HEALTH CARE

Patient Name_____
Date of Birth_____

Limited Release of Information to Family/Friends for Physician Clinics
HIM# 1315s

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 related to their involvement in my care or payment for my care.[1] 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*):

☐ Any non-sensitive[2] information regarding my health care or payment for my health care.

OR

☐ Only these things:

	My appointments – scheduling & reminders		My test results
	My after visit summary (AVS)		My bills
	Other:		

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

☐ Any non-sensitive[2] information regarding my health care or payment for my health care.

OR

☐ Only these things:

	My appointments – scheduling & reminders		My test results
	My after visit summary (AVS)		My bills
	Other:		

If I change my mind about the people or the contact information I have listed in this form, I will complete a new form with such changes.

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

PRINTED NAME & RELATIONSHIP (if not patient): _____

[1] 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 act on your behalf, your health care provider may share as much of your personal health information with that person as the law permits.

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.

[2] Non-sensitive information excludes mental health, alcohol and substance abuse, HIV and other communicable diseases, and genetic testing. **This form is not considered sufficient authorization to release sensitive information.**