CATAWBA VALLEY MEDICAL GROUP - PATIENT REGISTRATION FORM FOR FQHC CLINICS

PATIENT INFORMATION: DATE_____/_____/_____

NAME: LAST_____ FIRST _____ MIDDLE INITIAL _____

CIRCLE ONE: MR. MRS. MISS. MS. JR. NICKNAME OR PREVIOUS NAME: _____ (IF APPLICABLE)

DATE OF BIRTH _____/_____/_____ **SEX** □ F □ M □Unknown □Transgender **SOCIAL SECURITY #** _____ / _____ / _____

MAILING ADDRESS _____

STREET ADDRESS (IF DIFFERENT FROM MAILING) _____

CITY _____ STATE _____ ZIP_____ HOME PHONE (_____) _____ - _____

CELL PHONE (_____) _____ - _____ WORK PHONE (_____) _____ - _____ EXT. _____

NOTE:PLEASE ANSWER BOTH QUESTIONS ABOUT HISPANIC ORIGIN AND RACE. FOR THIS INFORMATION, HISPANIC ORIGINS ARE NOT RACES.

1. WHAT IS YOUR ETHNICITY? HISPANIC, LATINO OR SPANISH ORIGIN / *Mark one box.*

☐ NOT HISPANIC OR LATINO

☐ CHICANO ☐ CUBAN ☐ MEXICAN ☐ MEXICAN AMERICAN ☐ PUERTO RICAN

☐ OTHER HISPANIC, LATINO OR SPANISH ORIGIN- *print origin below, for example, Colombian, Dominican, Nicaraguan, Salvadoran, Spainard, etc.*_____

2. WHAT IS YOUR RACE? *Mark one or more boxes (if there is more than one race please mark all boxes that make up race)..*

☐ WHITE ☐ BLACK ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ ASIAN INDIAN ☐ CHINESE ☐ FILIPINO

☐ GUAMANIAN OR CHAMORRO ☐ JAPANESE ☐ KOREAN ☐ NATIVE HAWAIIAN ☐ SAMOAN

☐ VIETNAMESE ☐ OTHER ASIAN ☐ OTHER PACIFIC ISLANDER

☐ OTHER RACE- *Print race :*_____

INTERPRETATION SERVICES NEEDED? _____ IF SO, WHAT LANGUAGE OR SERVICE: _____

PATIENT MARITAL STATUS: ☐ SINGLE ☐ DIVORCED ☐ LEGALLY SEPARATED ☐ PARTNER

☐ MARRIED (SPOUSE NAME _____) ☐ WIDOWED ☐ UNKNOWN

PATIENT EMPLOYMENT STATUS: EMPLOYER NAME_____

☐ FULL TIME ☐ NOT EMPLOYED ☐ RETIRED ☐ PART TIME ☐ SELF EMPLOYED ☐ ACTIVE MILITARY ☐ DISABLED

APPOINTMENT AND HEALTH REMINDERS:

Is it okay to leave a message regarding your appointment reminder? ☐ **Yes** ☐ **No**

Please choose ONE option for your appointment reminder communication :

☐ **Phone** Preferred Phone: _____ Preferred time: ☐ Morning ☐ Afternoon ☐ Evening

☐ **Text** Preferred Phone: _____ Preferred time: ☐ Morning ☐ Afternoon ☐ Evening

May we leave a message to have you return our call with family, friends, or on an answering machine at:

HOME ☐ **Yes** ☐ **No** **CELL** ☐ **Yes** ☐ **No** **WORK** ☐ **Yes** ☐ **No**

I can STOP text reminders at any time by contacting my practice directly and requesting that text appointment reminders to be turned off

Please check any or all the following options to give us permission to send you important health reminders via:

☐ Email- emails are sent to the email address provided in the 'Web Enable/ Patient Portal Access' section of this Form- for the ages indicated

☐ Letter

RESPONSIBLE PARTY / POLICY HOLDER: (Responsible party is the person financially responsible for the patient statement/bills)

☐ SELF ☐ GUARANTOR - RELATIONSHIP TO PATIENT _____(Complete below if different than "Patient Information" above)

NAME_____ ADDRESS _____

CITY_____ STATE _____ ZIP_____ HOME PHONE (_____) _____ - _____

DOB_____/_____/_____ SOCIAL SECURITY # _____ / _____ / _____ SEX ☐ F ☐ M

EMPLOYER NAME _____ ADDRESS _____

WEB ENABLE/PATIENT PORTAL ACCESS

All Patients: By Providing your email address, we will be able to send you a patient satisfaction survey after your visit. **Patients age 0-12 and 18 and up**: If you would like access to your Personal Health Record (PHR) online, please check yes below and provide us with your email address. Patients age 13-17 do not have Patient Portal access.

☐ **Yes** ☐ **No** **Email Address:** _____

Due to our participation in Federal Healthcare Programs, we are required to collect the following information:

Are you a Veteran? ☐ Yes ☐No ☐ Choose not to answer

Are you a Migrant Worker: ☐ Yes ☐No ☐ Choose not to answer
(you have a temporary home for purposes of seasonal agricultural employment ex: farm work/ picking, planting, work with cows/ chickens)

Are you a Seasonal Worker: ☐ Yes ☐No ☐ Choose not to answer
(you have not established a temporary home for purposes of seasonal agricultural employment ex: farm work/ picking, planting, work with cows/chickens)

Homeless Status: Please check the statement that best describes your housing situation:
☐ I live in my home, which I rent, lease or own (Not Homeless= No)
☐ I live in a public or private facility that provides temporary shelters. Such as a shelter or a mission. (Homeless Shelter)
☐ I am staying in supportive or transitional housing, transitioning from a shelter or homeless environment (Transitional Housing)
☐ I am staying with a series of friends and/or extended family members on a temporary basis (Doubling Up)
☐ I live on the streets, in a car, park, sidewalk, in an abandoned building, or any unstable or non-permanent situation (Street)
☐ I live in a single room occupancy hotel/motel or other day-to-day paid housing (Other)
☐ Unknown
☐ Choose not to answer

Sexual Orientation: Do you think of yourself as: ☐ Straight or heterosexual ☐ Lesbian, gay or homosexual ☐ Bisexual
☐Something else ☐Don't know ☐Choose not to answer

What is your current gender identity (Check one): ☐ Male ☐ Female ☐ Transgender Male/Trans Man/ Female-to-Male (FTM)

☐ Transgender Female/ Trans Woman/ Male-to-Female (MTF) ☐ Genderqueer, neither exclusively male nor female

☐ Additional Gender Category/ (or Other), please specify: _____

☐ Choose not to answer

What sex were you assigned at birth on your original birth certificate? (Check one): ☐ Male ☐ Female ☐ Choose not to answer

How does patient want to be addressed? ☐ He/Him ☐ She/ Her ☐ They/Them ☐ Choose not to answer ☐ Other:_____

PHARMACY (RETAIL):

NAME _____

LOCATION _____

PHARMACY (MAIL ORDER):

NAME _____

LOCATION _____

I understand that Catawba Valley Medical Group may need to access my refill information at all of my pharmacies regarding the prescriptions that I have had filled. ☐ **Yes** ☐ **No**

EMERGENCY CONTACT: **Authorized to release medical information to Emergency Contact? ☐ Yes ☐ No**

NAME: LAST_____ FIRST _____ RELATIONSHIP TO PATIENT_____

ADDRESS_____ CITY _____ STATE _____ ZIP _____

HOME PHONE (_____) _____ - _____ WORK PHONE (_____) _____ - _____ EXT. _____

MOBILE/CELL PHONE: (_____) _____ - _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO: (example: spouse, child, or caregiver)

Name	Phone	Relationship to Patient

Consent to medical treatment: I voluntarily consent to healthcare treatment (i.e., physical and/or behavioral treatment) from the physicians, behavioral health providers, and staff of CVMG/ Kintegra, Inc. I consent to such diagnostic procedures, lab work (including HIV testing), and care deemed necessary by the physician, his or her assistant or designated consultants. I am aware that neither the practice of medicine nor the delivery of mental/behavioral health treatment are an exact science. No guarantees have been made to me regarding the results of treatments or examinations by my caregivers. I understand that CVMG/Kintegra employs a "team based" approach to the delivery of healthcare and that health information may be exchanged between Kintegra providers and staff members involved in my care to ensure appropriate treatment planning and adequate care. I consent to the use and disclosure of Protected Health Information (PHI) about me for treatment, payment and healthcare operations. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment under Title's V, XVIII and/or XIX of the Social Security Act is correct. I certify that I have read and understand this form.

Conditions of clinical and financial services: Your insurance will be automatically filed as a courtesy to you. Please be sure to provide a copy of your insurance card to staff. Insurance co-pays and unmet deductibles are due at time of service. I understand and acknowledge that I am liable for all charges designated my responsibility that is not paid by insurance.

***Authorization to release information*:** I hereby authorize my provider to release all information pertaining to my treatment to my insurance company or companies and to any other physician or health care provider to whom I may be referred. I hereby authorize regulatory and accrediting agencies to review my medical record during surveys or inspections. In an effort to improve my care, CVMG is participating in a health information exchange, which is a secure electronic database of patient information contributed by participating hospitals and providers. My medical information will be contributed to the health information exchange unless I choose not to participate or to "opt out".

Assignment of benefits: I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicaid, private insurance, and other health plans to: Catawba Valley Medical Group.

Notice of privacy practices: My signature below acknowledges that I have been given the opportunity to receive a full disclosure of the privacy practices as outlined by the health insurance portability and accountability act of 1996.

Missed Appointments: Should you need to cancel or reschedule an appointment, please contact our office 24 hours in advance or as soon as possible. We are here to serve you, but once three appointments have been missed within a rolling 12 month period, you may be dismissed from the practices of Catawba valley Medical Group and asked to seek care elsewhere.

Personal Valuables: I understand that CVMC/CVMG is not responsible for personal valuables brought into the practice or left in my vehicle.

Recording or Filming: Recording or Filming (to include photographs, video, electronic or audio media): I understand that from time to time Catawba Valley Medical Group (CVMG) may record or film me while care is being provided (for example, photo documentation of injuries). I understand that these recordings/films/photos will only be viewed internally for identification purposes; for the treatment, diagnosis or evaluation of my care; or for internal organizational use to assist in maintaining or improving quality of care and to educate medical staff.

I have read the Consent to Medical Treatment, Financial Information and other information above.
I understand and agree to its terms.

(PATIENT SIGNATURE) (DATE)

(RESPONSIBLE PARTY SIGNATURE) (RELATIONSHIP) (DATE) Rev 05.07.2024

CATAWBA VALLEY MEDICAL GROUP

PRIMARY CARE

☐ Catawba Valley Family Medicine-Bethlehem p: 828.732.5680 f: 828.732.5681	☐ Catawba Valley Family Medicine-Claremont p: 828.732.5050 f: 828.732.5051	☐ Catawba Valley Family Medicine-Graystone p: 828.732.5600 f: 828.732.5601	☐ Catawba Valley Family Medicine-Long View p: 828.732.5650 f: 828.732.5651	☐ Catawba Valley Family Medicine-Maiden p: 828.732.5000 f: 828.732.5001	☐ Catawba Valley Family Medicine-Medical Arts p: 828.732.5100 f: 828.732.5101	☐ Catawba Valley Family Medicine-Mountain View p: 828.732.5150 f: 828.732.5151	☐ Catawba Valley Family Medicine-North Hickory p: 828.732.5350 f: 828.732.5351
☐ Catawba Valley Family Medicine-Northeast Hickory p: 828.732.5550 f: 828.732.5551	☐ Catawba Valley Family Medicine-Parkway p: 828.732.5780 f: 828.732.5781	☐ Catawba Valley Family Medicine-South Hickory p: 828.732.5500 f: 828.732.5501	☐ Catawba Valley Family Medicine-Sherrills Ford p: 828.732.5450 f: 828.732.5451	☐ Catawba Valley Family Medicine-Taylorsville p: 828.732.5300 f: 828.732.5301	☐ Catawba Valley Family Medicine-Viewmont p: 828.732.5800 f: 828.732.5801	☐ Catawba Valley Family Medicine-West Mountain View p: 828.732.5250 f: 828.732.5251	☐ Catawba Valley Family Care - Newton p: 828.732.5180 f: 828.732.5181

MEDICAL RECORD RELEASE FORM

PATIENT NAME:_____
LAST FIRST MIDDLE MAIDEN

DATE OF BIRTH:_____ SOCIAL SECURITY #:_____

I HEREBY AUTHORIZE CATAWBA VALLEY MEDICAL GROUP (PLEASE CHECK ONE):

□ TO OBTAIN MY RECORDS FROM: _____

FAX #_____ PHONE#_____ ADDRESS_____

□ TO RELEASE MY RECORDS TO: _____

FAX #_____ PHONE#_____ ADDRESS_____

FOR THE PURPOSE OF (PLEASE CHECK ONE):

□ TRANSFER OF CARE
□ OTHER (LIST REASON) _____

MEDICAL RECORDS FROM THE FOLLOWING TIME PERIOD ARE TO BE RELEASED:

FROM_____ TO_____
Date Date

INFORMATION REQUESTED INCLUDES (PLEASE CHECK ALL THAT APPLY):

□ ALL RECORDS
□ DRUG, ALCOHOL TREATMENT RECORDS
□ PSYCHIATRIC TREATMENT RECORDS
□ AIDS (acquired immunodeficiency syndrome) or infection with HIV (human immunodeficiency virus)
□ OTHER: _____

Right to terminate or revoke authorization: This authorization shall expire (60) days from this date. You may revoke or terminate this authorization by submitting a written revocation to our practice.

Potential for re-disclosure: I understand that once the authorized organization or person receives this information, then this information may be subject to re-disclosure. It may not be possible to ensure your right to protection of the privacy of this information once our practice discloses it to another party.

Effect of refusing authorization: If you refuse to sign this authorization, our practice will not deny you any treatment except research-related treatment or treatment that you have requested for the purpose of disclosure to others.

Rights of the individual: You have the right to contact and request that your information be protected from anyone that you release your health information to.

_____ _____
Signature of Patient or Patient's Legal Representative and Relationship to the Patient Date