CATAWBA VALLEY PHYSICAL MEDICINE & REHAB - PATIENT REGISTRATION FORM FOR

PATIENT INFORMATION:

DATE_____/_____/_____

NAME: LAST_____ FIRST _____ MIDDLE INITIAL _____

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

MAILING ADDRESS _____

STREET ADDRESS (IF DIFFERENT FROM MAILING) _____

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

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

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

Primary Care Provider: _____

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

MARITAL STATUS: □ SINGLE □ DIVORCED □ LEGALLY SEPARATED □ PARTNER

□ MARRIED (SPOUSE NAME _____) □ WIDOWED □ UNKNOWN

EMPLOYMENT STATUS: EMPLOYER NAME _____

ADDRESS _____

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

STUDENT STATUS: □ FULL TIME □ PART TIME □ NOT A STUDENT

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: (_____) _____ - _____

INSURANCE INFORMATION: Please provide us with your insurance card so that we can scan a copy into your medical record.

Primary Policyholder Name: _____ DOB: _____
Relationship to patient: _____

RESPONSIBLE PARTY: (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 _____

ADVANCE DIRECTIVE: Do you have a Living Will or an Advance Directives document? Please check all that apply

□ NO □ DNR (Do Not Resuscitate) □ POA (Power of Attorney) □ Living Will

If not, our staff will be glad to provide you with information. If you have already signed a living will or advanced directive form, please submit a copy to this office for our records.

□ I wish to receive Advanced Directive Information

□ I do not wish to receive Advanced Directive Information

□ FOR CLINIC USE ONLY: Information given to Patient

If you would like to access your Personal Health Record (PHR) online, please check yes below and provide us with your email address. By providing your email address we will also be able to send you a patient satisfaction survey after your visit.

□ **YES** □ **NO** **Email Address:** _____

May we leave a message to have you return our call with family, friends, or on an answering machine at: **HOME □ YES □ NO**
WORK □ YES □ NO

RACE: _____ ETHNICITY: □ HISPANIC □ NON-HISPANIC

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

PATIENT EDUCATIONAL NEEDS:

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

Name	Phone	Relationship to Patient

PHARMACY (RETAIL):

NAME _____

ADDRESS / LOCATION _____

PHONE (_____) _____ - _____

FAX (_____) _____ - _____

PHARMACY (MAIL ORDER):

NAME _____

ADDRESS / LOCATION _____

PHONE (_____) _____ - _____

FAX (_____) _____ - _____

MAIL ORDER UNIQUE MEMBER ID # _____

PRESCRIPTION REFILLS:

I understand that Catawba Valley Physical Medicine & Rehab may need to access my refill information at all of my pharmacies regarding the prescriptions that I have had filled. □ YES □ NO

PLEASE LIST THE NAMES AND PHONE NUMBERS OF OTHER HEALTHCARE PROFESSIONALS THAT YOU SEE:

Type of Doctor/ Specialty	Provider/ Doctor Name	Phone Number

Patient Name:	**Date of Birth:**
Current Medications/Supplements	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.
Past Medical History Please list all chronic medical problems that you have, such as high blood pressure or Diabetes	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.
Medication Allergies	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.
Family Medical History	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.
Past Surgical History	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.
Tobacco History	
Are you Current/Former/Never a smoker?	If you use to smoke how long since you stopped?
If you currently smoke: How many do you smoke per day?	Are you interested in quitting? Ready to quit/Think about quitting/Not ready
Alcohol History	
Did you have a drink containing alcohol in the past year?	
If yes: How often did you have a drink? Never/Monthly or less/2-4 times a month/2-3 times per week/4+ times a week	How many drinks on a typical day did you drink in the last year?
How often did you have 6 or more drinks on one occasion in the last year?	
Fall Risk	
Are you afraid of falling?	Have you fallen in the past 6 months? If so how many times?

Patient Name:	**Date of Birth:**
Daily Assets **Please list items that assist you in your daily routine such as reading glasses, hearing aids, walker, wheelchair**	
Abuse History	
Have you experienced abuse in childhood?	Have you experienced abuse in adulthood?
If yes: what type of abuse?	Have you observed abuse in your lifetime?
Do you feel safe in your home?	
Education	
What level of education did you complete?	
How do you learn best? Reading/Viewing/Listening/Doing	
Do you have a barrier to learning?	If yes, please explain:
Do you require a caregiver?	
24/7 care	Daily Assistance
Live in	Weekly Assistance
None	Based on availability

Housing		
What type of home do you live in?	Single Level	Multi-Level
	Nursing Facility	Assisted Living

Review of Systems

Please circle all that apply to you

General	Fever/Chills	Weight Gain/Loss	Fatigue	Headache		
Respiratory	Shortness of breath					
Cardiology	Ankle Swelling	Leg Pain while walking			Chest Pain	
Genitourinary	Frequent Urination	Urgency	Incontinence		Difficulty urinating	
Neurology	Weakness	Numbness	Seizures	Tingling	Difficulty with Speech/Swallowing	
Musculoskeletal	Arthritis	Muscle aches/Pains	Joint pain	Recent Injury	Swelling	
	Stiffness	Cramps	Back Pain		Difficulty Rising from Chair	
Psychiatry	Anxiety	Depression	Irritability		Memory Loss	

Other Symptoms:

Catawba Valley Medical Center

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CONSENT TO ADMISSION, TREATMENT and/or DIAGNOSTIC SERVICES

I. Consent To Hospital Admission, Treatment, and/or Diagnostic Services

I do voluntarily consent to such diagnostic procedures and hospital care deemed necessary by the attending physician, his assistant or his designated consultants, including testing for Human Immunodeficiency Virus (HIV).

I understand that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the result of examination or treatment in this hospital. I also understand that CVMC is affiliated with various institutions of higher learning in an effort to facilitate clinical education of the next generation of healthcare providers. In accordance with these affiliations, I understand healthcare students supervised by CVMC staff or physicians may observe and/or participate in the delivery of my medical treatment and should I decline, my access to care will not be delayed or otherwise affected. I further understand that physicians and providers practicing at the hospital may not be employed by the hospital. I consent to evaluation/treatment by physicians and providers with the understanding that they may be independent contractors privileged to practice at the hospital, but employed by an entity separate and distinct from the hospital. I have made no assumptions and have drawn no conclusions about the employment status of the physicians and providers caring for me simply because they have provided or will be providing care to me at the hospital.

II. Conditions of Admission, Treatment, and/or Diagnostic Services

1. **Personal Valuables:** I understand that the hospital maintains a safe and will hold on deposit any money or valuables for which the hospital has issued a safekeeping receipt, and the hospital is not responsible for personal valuables retained in my patient room. Personal valuables include items such as money, dentures, glasses, hearing aids, clothing, jewelry, and books.
2. **Recording or Filming** (to include photographs, video, electronic, or audio media): I understand that from time to time Catawba Valley Medical Center (CVMC) may record or film me while care is being provided (for example, in the Operating Room). I understand that these recordings/filming 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 employees or medical staff.
3. **Release of Information:** I authorize CVMC to release information necessary for external and internal quality improvement activities, including information required by regulatory and accrediting bodies. As described in the Notice of Privacy Practices, CVMC may allow health care providers to have access to my medical information for treatment, payment and health care operations. In an effort to improve my care, CVMC 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".
4. **Assignment of Benefits:** I assign any and all insurance benefits directly to Catawba Valley Medical Center and physician(s) who perform services, otherwise payable to me including medical, surgical benefits, major medical benefits, liability benefits and worker's compensation medical benefits.
5. **Financial Agreement:** I understand and acknowledge that I am responsible for all charges not paid by my insurance plan including, but not limited to, deductibles, co-insurance, co-pays, non-covered take home or self-administered drugs and non-covered services. I agree to be responsible for and pay any services that my insurance does not. I understand that uninsured medication costs may be credited to my account if I qualify for certain benefit programs. I agree to allow Pharmacy Health solutions (PHS) to act as my representative and apply on my behalf for these programs.
   Electronic options available for payment are credit cards, debit cards, and electronic checks. I give CVMC authorization to charge my bank account or debit card on or after this date of service in the amount determined by me. I authorize refunds to my insurance for their overpayments as necessary. All outstanding accounts must be satisfied before I will receive a refund of patient payment.
6. **Authorization to call any number I have provided to CVMC:** I authorize CVMC to call any number that I have provided or any number at which CVMC reasonably believes they can contact me, including calls to mobile, cellular or similar devices for any lawful purpose. I agree to any fee(s) or charge(s) that I may incur for incoming calls from CVMC and/or outgoing calls to CVMC, to or from any such number, without reimbursement from CVMC.
7. **Medicare and Medicaid Patient Certification:** I certify that the information given by me in applying for payment under Medicare (Title XVIII) and/or Medicaid (Title XIX) of the Social Security Act is correct. I request and understand that payments of authorized benefits will be made on my behalf to CVMC and physicians providing services.

Catawba Valley Medical Center

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CONSENT TO ADMISSION, TREATMENT and/or DIAGNOSTIC SERVICES

8. Patient Rights: Catawba Valley Medical Center strives to protect the rights of each patient.

a. **Access to Care:** Patients have the right to impartial access to medically indicated treatments and can expect to have emergency procedures implemented without delay.
b. **Respect:** Patients have the right to considerate and respectful care given by competent personnel.
c. **Dignity:** Patients have the right to be treated with dignity.
d. **Privacy and Confidentiality:** Patients have the right to expect that any discussion and all written communications pertaining to their care be treated as confidential.
e. **Personal Safety:** Patients have the right to expect reasonable safety precaution be taken, in terms of practices and the environment in which care is provided. Patients have the right to be free from restraints that are not medically necessary.
f. **Identity:** Patients have the right to know the identity, professional status and relationships of those providing services, including knowing who is primarily responsible for their care.
g. **Information:** Patients have the right to be informed about the outcomes of their care.
h. **Communication:** Patients have the right to verbal and written communications and access to people that are authorized to act on the patient's behalf to assert or protect their rights. When the patient does not understand the predominant language of the community or is hearing impaired, access to an interpreter will be provided.
i. **Visitation:** Patients have the right to receive the visitors whom he or she designates. All visitors will enjoy full and equal visitation privileges consistent with patient preferences and a "support person" may be identified by the patient.
j. **Consent:** Patients have the right to informed participation in decisions involving their health care.
k. **Consultation:** Patients have the right to consult with a specialist.
l. **Participation in the Plan of Care:** Patients have the right to participate in the development, implementation and revision of his/her plan of care. Patients may refuse treatment to the extent permitted by law and are informed of the medical consequences of such refusal.
m. **Knowledge of Continuing Care Needs: P**atients may not be transferred to other facilities unless they have received complete explanation of the need for the transfer and the transfer is acceptable to the patient and the other facility.
n. **Comfort:** Patients have the right to quick response directed to optimize pain management.
o. **Financial Explanation:** Patients have the right to request and receive an itemized and detailed explanation of their total bill.
p. **Hospital Rules and Regulations:** Patients have the right to access to the hospital rules and regulations.
q. **Grievances:** Patients have the right to expect that care and services are provided in a timely, reasonable and consistent manner. When a patient issue cannot be resolved promptly by the staff present, the patient has the right to file a formal grievance.
r. **Children and Teens:** Children and teens have the right to make choices and let our staff know how they want to be involved in their care. Children's right to grow, play, learn, rest and feel secure will be respected.

All departments at Catawba Valley Medical Center are licensed and regulated by:
North Carolina Department of Health and Human Services: Division of Health Service Regulation
Acute and Home Care Branch
2717 Mail Service Center, Raleigh, North Carolina 27699-2711
Phone: 919-855-4500 or 1-800-624-3004
The Disability Rights of North Carolina has the power to investigate complaints at any 24-hour behavioral health facility in the state. To contact Disability Rights of North Carolina, please call 1-877-235-4210 or email info@disabilityrightsnc.org
The Joint Commission, whose mission is to monitor healthcare organizations' compliance with patient quality and safety of care standards. If a patient and/or patient's designee wishes, The Joint Commission may be contacted at 800.994.6610 or patientsafetyreport@jointcommission.org Medicare patients have the right to submit a complaint regarding quality of care, disagreement with a coverage decision or appeal a perceived premature discharge to Kepro, The Quality Improvement Organization (QIO). Kepro may be contacted at 844.455.8708 or via TTY at 855.843.4776.

If you would like a more detailed description of these patient rights, please ask your nurse, healthcare provider, or call 828-326-3720.

9. **Notice of Privacy Practices:** 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.

Date_____ Time_____ _____
Signature of Patient/Legal Representative (Specify Relationship and Explain)

Date_____ Time_____ _____
Signature of Witness

Authorization for the Disclosure of Protected Health Information From/To
Catawba Valley Medical Center
Catawba Valley Physical Medicine and Rehabilitation

3246 6th Ave SE
Hickory, NC 28602
(828)732-7249 Phone (828)732-7231 Fax

Patient Name: _____DOB: _____
Social Security Number: XXX-XX- _____

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. No individual has coerced me into signing this authorization and I am providing this authorization under my free will. I understand that once the authorized organization or person receives this information, then this information may be subject to redisclosure, and may no longer be protected by federal or state laws.

I, _____, hereby consent to and authorize Catawba Valley Medical Center to use or disclose from/to the following: _____ medical records for the purpose of:
□ Establishing Medical Care □ Communication with Family □ Referrals
□ Other: _____

The information requested includes: Date(s) of service from _____ to _____

□ Discharge Summary □ History and Physical □ Consultation Report
□ Ultrasound Reports □ Progress Notes □ Laboratory Reports
□ X-ray reports □ Photographs, digital or other images
□ Other: _____

This authorization expires one year after the date of my signature unless another date or event is written here: _____.

I understand that I may revoke this authorization in writing. However, the revocation is not effective to the extent that the entity or person using or disclosing information has already relied on this authorization.

Signature of Patient: _____Date: _____

Witness: _____ Date: _____

Signature of someone other than the Patient and Authority to Sign:

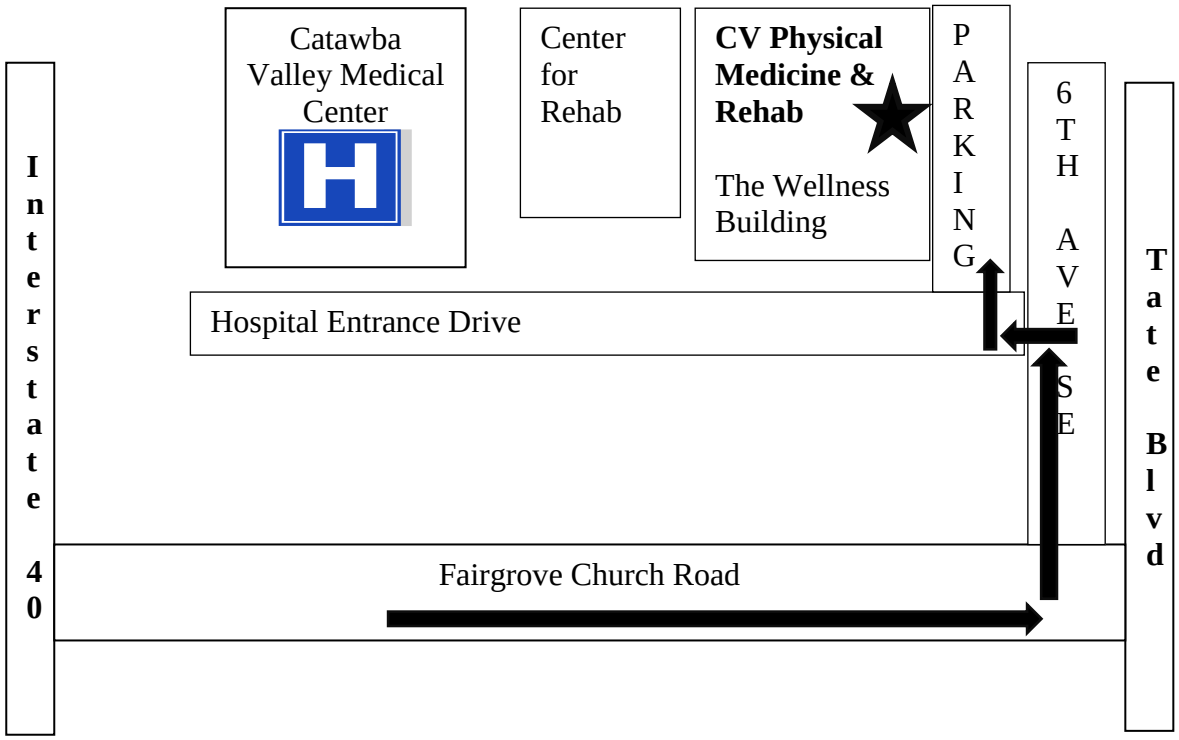
_____
(signature) Authority/Relationship

Please Complete this form for providers you have seen in the past for the medical issue you will be seen for in our office.

CATAWBA VALLEY PHYSICAL MEDICINE & REHAB

3246 6th Ave SE Hickory, NC 28602
828-732-7249

Please arrive 30 minutes prior to your appointment time.
Please bring all medications with you at the time of your appointment.



FROM INTERSTATE 40:
Take exit 128, head toward Catawba Valley Medical Center, go through the stop light that is in front of the main entrance to the hospital. Turn onto the next road on the left. Then take the next left. We are located in the Wellness Building on the right.

From Tate Blvd:
Turn on to Fairgrove Church Road, take the first road on the right, turn on to the next road on the left. We are in the Wellness Building located on the right.