CATAWBA VALLEY MEDICAL GROUP - PATIENT REGISTRATION FORM – PRIMARY AND SPECIALTY CARE

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. _____

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: (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 _____

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

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 □ FOR CLINIC USE ONLY: Information given to Patient

□ I do not wish to receive Advanced Directive Information

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

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:_____

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 to access 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:** _____

RACE: _____ ETHNICITY: □ HISPANIC □ NON-HISPANIC

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

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

PATIENT EDUCATIONAL NEEDS:

How do you learn best? Please Circle or explain in the area labeled "Other" how we can best serve you.

(Circle one): Hearing information or reading information?

Other: Please List. _____

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

For Specialty Appointments: Who is your Primary Care Provider? _____

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

My signature below signifies that the above information is true to the best of my knowledge.

(PATIENT SIGNATURE) (DATE)

(RESPONSIBLE PARTY SIGNATURE) (RELATIONSHIP) (DATE)

ONLY REQUIRED FOR NEW PATIENTS

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

Type of Doctor/ Specialty	Provider/ Doctor Name	Phone Number
Cardiologist/ Heart Doctor		
Endocrinologist		
Eye Doctor		
Gastroenterologist		
Gynecologist (if applicable)		
Pulmonologist (Lung Doctor)		
Dermatologist		
Urologist		
Neurologist		
Rheumatologist		
Orthopedic		
Pain Clinic		
Podiatrist		

CATAWBA VALLEY MEDICAL GROUP
CONSENT TO TREATMENT AND FINANCIAL AGREEMENT

Consent

I voluntarily consent to such diagnostic procedures and care deemed necessary by the physician, his or her assistant or designated consultants. I understand the practice of medicine and surgery is not an exact science and I further acknowledge that no guarantees have been made to me as to the result of examination or treatment in this clinic.

Insurance

I hereby assign all medical and/or surgical insurance benefits directly to Catawba Valley Medical Group and physician(s) who perform services, otherwise payable to me including, Medicaid, private insurance, other health plans and worker's compensation medical benefits. I understand my insurance will automatically be filed as a courtesy. I understand all insurance co-pays and unmet deductibles are due at time of service.

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 and non-covered services. I agree to be responsible for and pay any services that my insurance does not.

I understand payment is due at time of service. Options for payment are cash, check, Visa, MasterCard, Discover and American Express. I give CVMG authorization to charge by 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. Unpaid balances will be referred to an outside agency for collection. Nonpayment for Access One Med Card balances will also be referred to an outside agency for collection.

I understand that CVMG also provides an additional payment option for patients whose needs require extended terms to pay balances in full. The AccessOne Med Card allows patients to make monthly payments at a minimal interest rate. Applications for AccessOne are available at the front desk.

I understand that visits to Catawba Valley Urgent Care Saturday Clinic and Catawba Valley Urgent Care - Piedmont will include an additional convenience charge for after-hours service.

Missed Appointments

Should you need to cancel or re-schedule 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 rolling12 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.

Release of Information and Notice of Privacy Practices

I authorize CVMG 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, CVMG 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, 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".

I have read the Consent to Treatment and Financial Agreement, I understand, and agree to its terms. 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.

Patient Printed Name: _____ **Patient Date of Birth**:_____

X_____ _____

Patient or Responsible Party Signature **Date**

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