CATAWBA VALLEY MEDICAL GROUP - PATIENT REGISTRATION FORM – CATAWBA VALLEY FAMILY HEALTH CENTERS-EHC

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. _____

RACE: _____ ETHNICITY: ☐ HISPANIC ☐ NON-HISPANIC

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

PRIMARY CARE PROVIDER_____

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

☐ MARRIED (SPOUSE NAME _____) ☐ WIDOWED ☐ UNKNOWN

PATIENT EMPLOYMENT STATUS: DEPARTMENT NAME _____ ☐ FULL TIME ☐ PART TIME

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

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

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:_____

PHARMACY (RETAIL):

NAME _____

LOCATION _____

PHARMACY (MAIL ORDER):

NAME _____

LOCATION _____

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**

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: (_____) _____ - _____

CONSENT TO TREAT MINOR:

If patient is a minor, can patient receive medical care without a parent/guardian being present? ☐ **YES** ☐ **NO**

If patient is a minor, who can authorize medical care other than a parent/guardian, please list: _____

If patient is a minor, parent sign here for permission to treat in your absence: _____

Parent Signature Date

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

Name	Phone	Relationship to Patient

Consent to medical treatment: 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.

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.

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 8.29.23

CATAWBA VALLEY FAMILY HEALTH CENTERS

Employee Health Connection

p: 828.465.7674
f: 828.465.7905

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: _____
- ☐ 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