GRANVILLE HEALTH SYSTEM

PATIENT PAYMENT POLICY

Patients with health care insurance:

- We will happily file your claim with your insurance carrier. If you have secondary insurance we will file both insurance claims.
- Patients will be required to pay their co-pay, co-insurance and/or deductibles at the time of their visit.
- Patients who have Medicare only will be required to pay their 20% co-insurance and/or deductible.
- Patients who have Medicaid will be required to pay their co-pay for hospital stays and this will be collected at the first office visit after hospitalization.
- Patients with unpaid balances will be ask to pay the balance or set up a payment plan. We reserve the right to reschedule your appointment for non-payment.

Patients without health care insurance:

- If you have no insurance we offer medical care for the same fee as NC Medicaid and payment is required at time of visit.

There is a 20% discount with bills paid within 30 days of first billing

www.ghsHospital.org

Granville HEALTH SYSTEM
Quality Care...Close To Home

Find us on: facebook.

QUALITY CARE
IN YOUR NEIGHBORHOOD

Instructions for filling out GSA New Patient Forms

Please be sure to sign and date pages 2,6,7,8,9,10. (Page 6 must still be signed by male patients, even though that page pertains to women and children).

A complete copy of the GSA Notice of Privacy Practices will be provided to you upon arrival at Granville Surgical Associates.

Our office is in Oxford at 102 C Professional Park Drive, and our entrance is at the rear of the Granville Family Medicine building across from Granville Medical Center.

Bring these completed forms, your insurance card (s) and copay with you to your **CONSULTATION appointment on:**

_____

NOTE: It is expected that all copays & fees be paid when services are rendered. (Check your card for the SPECIALIST copay amount).

Completing these forms and bringing them with you will be very helpful for both you and our office staff. We thank you in advance for taking the time to do this.

If you have any questions about your appointment please call the office at **919-603-0368, Monday through Thursday, from 8:30-5 and Friday from 8:30-12.**

Granville Surgical Associates
102 C Professional Park Drive
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(919)603-0842 - fax

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gsa@granvillmedical.com

Health History – Confidential

There are five (5) total pages to this form. Please sign the first and last pages and fill in as much information as you are able. If you have any questions about this form, please ask the receptionist or the doctor before you leave today.

Name:_____ Today's Date:_____

Birth Date:_____ Age:____ Height:_____ Weight:_____

Primary Care Doctor:_____

Do you see any other doctors? Y / N
Doctor's Name Why do you see this doctor?

WHAT IS YOUR PRIMARY LANGUAGE? **ENGLISH / OTHER** _____
Do you have any communication needs? Y / N _____

DO YOU HAVE A LIVING WILL? **Y / N**
Please provide a copy if you have one.

ARE YOU AN ORGAN DONOR? **Y / N**

WHO MAY WE GIVE OUT YOUR MEDICAL INFORMATION TO?

- ☐ Myself
- ☐ Spouse
- ☐ Parents
- ☐ Other: _____

WHAT IS YOUR RELIGION? _____

WHAT IS THE REASON YOU ARE COMING TO SEE THE DOCTOR?

Patient Signature:_____ Date:_____

PLEASE SIGN THIS PAGE

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PLEASE LIST THE MEDICATIONS YOU ARE PRESENTLY TAKING:

☐ I DO NOT TAKE ANY MEDICATIONS PRESENTLY (CHECK HERE)

NAME	DOSE	FREQUENCY

PLEASE LIST ANY "OVER THE COUNTER" MEDICATIONS YOU ARE TAKING:

☐ I DO NOT TAKE ANY OVER THE COUNTER MEDICATIONS (CHECK HERE)

NAME	DOSE	FREQUENCY

Do you take any steroids: Y / N
Do you take aspirin daily: Y / N
Do you take any blood thinners: Y / N
Do you take antibiotics for dental procedures: Y / N

PLEASE LIST ANY MEDICATION ALLERGIES THAT YOU HAVE:

☐ I DON'T HAVE ANY MEDICATION ALLERGIES (CHECK HERE)

MEDICATION	REACTION

PLEASE LIST ANY PREVIOUS SURGERIES:

☐ I HAVE NEVER HAD SURGERY BEFORE (CHECK HERE)

PROCEDURE	DATE	WHY DID YOU HAVE THIS SURGERY?

Do you have any metal implants: Y / N

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CHECK IF YOU HAD ANY OF THE FOLLOWING SYMPTOMS IN THE PAST YEAR:

General
- ☐Appetite Poor
- ☐Chills
- ☐Fatigued
- ☐Fever
- ☐Sweats
- ☐Weight Loss
- ☐Weight Gain

Eyes
- ☐Blurry Vision
- ☐Double Vision
- ☐Flashing Lights

Eye/Ear/Nose/Throat
- ☐Earaches
- ☐Ear Discharge
- ☐Ringing in Ears
- ☐Vertigo
- ☐Nose Bleeds
- ☐Sinus Congestion
- ☐Snoring / Sleep Apnea
- ☐Mouth Sores
- ☐Bleeding Gums
- ☐Difficulty Swallowing
- ☐Hoarse Voice
- ☐Sore Throat
- ☐Reflux

Respiratory
- ☐Chronic Cough
- ☐Shortness of Breath
- ☐Spitting up blood
- ☐Wheezing

Cardiovascular
- ☐Chest Pain
- ☐Swelling of Ankles
- ☐Palpitations

Gastrointestinal
- ☐Abdominal Pain
- ☐Bloating
- ☐Chronic Diarrhea
- ☐Change in Bowels
- ☐Gas
- ☐Heartburn
- ☐Nausea
- ☐Vomiting
- ☐Vomiting Blood
- ☐Rectal Bleeding

Urinary
- ☐Blood in Urine
- ☐Frequent Urination
- ☐Kidney Stones
- ☐Pain on Urination
- ☐Stress Incontinence
- ☐Urine Leakage
- ☐Burning on Urination

Musculoskeletal
- ☐Joint Pain
- ☐Joint Swelling
- ☐Back Pain
- ☐Muscle Weakness

Neurological
- ☐Dizziness
- ☐Fainting
- ☐Headache
- ☐Memory Loss
- ☐Numbness
- ☐Seizures

Psychiatric
- ☐Depression
- ☐Restlessness
- ☐Difficulty Sleeping
- ☐Suicide Attempt

Heme/Lymph
- ☐Bruises Easily
- ☐Enlarged Lymph Nodes

Endocrine
- ☐Excessive Hunger /Thirst
- ☐Heat/Cold Intolerance
- ☐Excessive Urination

Allergy/Immune
- ☐Hay Fever
- ☐Immunosuppressive Drugs
- ☐Immune Therapy

Men only
- ☐Erection Difficulties
- ☐Lump in Testicles
- ☐Penis Discharge
- ☐Testicular Pain

Women only
- ☐Abnormal PAP smear
- ☐Bleeding between periods
- ☐Breast Mass
- ☐Extreme Menstrual Pain
- ☐Irregular Menstrual Periods
- ☐Vaginal Discharge

Skin
- ☐Change in Moles
- ☐Hair Loss
- ☐Skin Becoming Dryer
- ☐Hives
- ☐Itching
- ☐Rash
- ☐Sores that won't heal

Childhood Diseases
- ☐Chicken Pox
- ☐Measles
- ☐Mumps
- ☐Mononucleosis
- ☐Polio
- ☐Rheumatic Fever
- ☐Scarlet Fever

CHECK IF YOU HAVE EVER HAD ANY OF THE FOLLOWING CONDITIONS:

- ☐HIV Positive/AIDS
- ☐Alcoholism
- ☐Anemia
- ☐Anorexia
- ☐Appendicitis
- ☐Arthritis
- ☐Asthma
- ☐Bleeding Disorders
- ☐Blood Clots
- ☐Breast Lump
- ☐Bronchitis
- ☐Bulimia
- ☐Cancer_____
- ☐Cataracts
- ☐Chemical Dependency
- ☐Diabetes
- ☐Emphysema/COPD
- ☐Epilepsy/Seizures
- ☐Fibromyalgia
- ☐Glaucoma
- ☐Gout
- ☐High/Low Thyroid
- ☐Heart Attack
- ☐Heart Disease
- ☐Hepatitis
- ☐Hernia
- ☐High Cholesterol
- ☐Hypertension
- ☐Kidney Disease
- ☐Kidney Failure
- ☐Kidney Stones
- ☐Leg Ulcers
- ☐Liver Cirrhosis
- ☐Mitral Valve Prolapse
- ☐Heart Murmur
- ☐Migraine Headaches
- ☐Multiple Sclerosis
- ☐Pacemaker/Defibrillator
- ☐Phlebitis/Blood Clots
- ☐Pneumonia
- ☐Prostate Problem
- ☐Sickle Cell Anemia
- ☐Stomach Ulcers
- ☐Stroke
- ☐Tuberculosis
- ☐Psychiatric Care
- ☐Transfusion

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HAVE YOU HAD ANY X-RAYS DONE RECENTLY? Y / N

Type Where Done

HAVE YOU TRAVELED OUTSIDE THE U.S. RECENTLY? Y / N

If so, where? _____

DO YOU SMOKE? Y / N

If yes, how many packs per day____ How many years____
If you quit, how long ago?____

HAVE YOU HAD A FLU VACCINATION? Y / N WHEN?_____

DO YOU DRINK ALCOHOL? Y / N

If yes, how much?_____

DO YOU TAKE ANY STREET DRUGS? Y / N

Which ones? _____

DO YOU HAVE SLEEP APNEA? Y / N

Do you use a CPAP Machine? Y / N
Do you wake up at night out of breath? Y / N
Do you Snore? Y / N

FAMILY HISTORY:

Any history of cancer in your family Y / N

If yes: Relation Type of Cancer

Any other family medical problems Y / N

If yes, please describe:

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Date of Last Menstrual Period:
Age when menstrual periods started:
Do you still have regular menstrual periods Y / N
If no, how old were you when they stopped:
How many times have you been pregnant ____
How many children do you have ____
Do you or did you ever take birth control pills Y / N
If so, for how long? _____
Do you or did you ever take hormone replacement Y / N
If so, for how long? _____
Menstrual Problems Y / N
If yes, please describe:

Date of last Pelvic Exam: _____
Date of Last Mammogram: _____
Do you perform a self-breast exam? Y / N

PEDIATRIC PATIENTS:

Does/did the child use an Apnea monitor? Y / N
Was the child premature? Y / N
How many weeks? ___
Any congenital health problems? Y / N
If yes, please explain:

Are all vaccinations up to date? Y / N

Patient Signature:_____ Date:_____

Physician Review:_____ Date:_____

PLEASE SIGN THIS PAGE

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Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that a copy of the Granville Surgical Associates Notice of Privacy Practices has been provided to me. The notice contains information regarding potential uses and disclosures of my protected health information (as that term is defined under the Health Insurance Portability and Accountability Act of 1996 "HIPPA") that may be made by Granville Surgical Associates, and of my rights and Granville Surgical Associate's legal duties with respect to my protected health information. I have had the opportunity to review the Notice and take a copy with me if I so choose.

_____
Patient's Name

_____
Patient's Signature

_____
Date

Disclosure Authorization:

I give permission that Granville Surgical Associates may:

☐Leave a detailed message on my home answering machine or voice mail
☐Leave a verbal detailed message with my spouse
☐Call my workplace phone number and leave a message
☐Call my workplace phone number and speak to me only
☐May discuss my condition(s) with _____
☐None of the above

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Photograph Consent Form

Patient's Name _____

Date of Birth _____

Chart Number _____

Date _____

I, _____, hereby give my consent to have photographs made of myself and/or any wounds, lesions, masses, etc. in order to document my care and progression of treatment. I understand that Granville Surgical Associates will retain all rights to these photographs. I understand that images will be stored in a manner that will protect my privacy. Images that identify me will be released and / or used outside the office only upon written authorization from myself or my legal representative.

The term "photograph" as used herein includes video or still photography, in digital or any other format, and any other means of recording or reproducing images.

Signature: _____ Date: _____

Witness: _____ Date: _____

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Release of Medical Information

I, _____ (DATE OF BIRTH) _____allow Granville Surgical Associates to obtain copies of the following medical information:

- ☐ Medical Records
- ☐ X-Rays
- ☐ Laboratory Studies
- ☐ Pathology
- ☐ Other: _____

Please mail or fax information to the above address.

_____
Patient Signature

_____
Date

Granville HEALTH SYSTEM
Quality Care...Close To Home

Granville Surgical Associates

Patient Registration Form

Today's Date:	Pharmacy	Pharmacy Location/City

PATIENT INFORMATION

Patient's Last Name	First	Middle	Social Security Number	Birth Date

Sex	Marital Status	Race	Ethnicity
☐M ☐F	☐Single ☐Married ☐Div ☐Sep ☐Widowed		☐Hispanic ☐Latino ☐Non-Hispanic

Street Address	City	State	Zip Code	Patient Email Address

Home Phone No.	Cell Phone No.	Occupation/Title	Employer	Work Phone No.

Primary Care Physician/Practice	Practice Email Address	Practice Telephone No.

How Did You Hear About Granville Internal Medicine? ☐*Billboard(4)* ☐*Direct Mail(19)* ☐*Employee(9)* ☐*Employer/Work(14)* ☐*Fair/Festival(16)* ☐*Family(7)* ☐*Friend(1)* ☐*Health Department(21)* ☐*Hospital/ED(5)* ☐*Insurance Network(18)* ☐*Meal & More(12)* ☐*Newsletter(10)* ☐*Newspaper Ad(2)* ☐*Other(17)* _____ ☐*Physician/Provider(6)* ☐*Radio(15)* ☐*Self(20)* ☐*State Health Plan(11)* ☐*Online/Website(13)* ☐*Yellow Pages(3)*

INSURANCE INFORMATION *(Please Give Your Insurance Card to the Receptionist for Copying)*

Person Responsible for Bill	Birth Date	Address (If different)	Home Phone No.

Occupation	Employer	Employer Address	Employer Phone No.

Please indicate primary insurance ☐Aetna ☐BCBS of NC ☐Cigna ☐Medicaid ☐Medicare ☐State Plan ☐Med Cost ☐WellPath ☐Other: _____

Workman's Compensation: (Authorization REQUIRED from company)
Supervisor: Phone Number:

Subscriber Name	Subscriber Social Security No.	Birth Date	Group No.	Policy No.	Co-Payment

Patient's Relationship to Subscriber ☐Self ☐Spouse ☐Child ☐Other _____

Name of Secondary Insurance (If applicable)	Subscriber's Name	Group No.	Policy No.

Patient's Relationship to Subscriber ☐Self ☐Spouse ☐Child ☐Other _____

Language Preference	Contact Preference	Learning Preference	Dominant Hand
	☐Phone ☐E-Mail ☐Postal Service	☐Visual ☐Speaking ☐Reading	☐Right ☐Left ☐Ambidextrous

IN CASE OF EMERGENCY *(Local friend or relative not living at same address)*

	Relationship to Patient	Address	Home Phone No.	Cell/work No.	May we Speak to them about you?
First Emergency Contact					
Second Emergency Contact					

The above information is true to the best of my knowledge. I hereby authorize the physician, provider or staff member of Granville Surgical Associates to administer any treatment, medical or surgical, that is deemed necessary or advisable to diagnose and/or treat me. This may include X-rays or imaging, laboratory tests, and anesthesia. I request payment of authorized Medicare/Insurance Benefits on my behalf be made to Granville Surgical Associates, for any service furnished to me. I authorize any holder of Medical Information about me to release to Medicare/Insurance company any information needed to determine these benefits or benefits payable for related services. I also assume full responsibility for any balance due for services provided me. In addition, I authorize Granville Health System, pursuant to its agreement with Granville Health Inc., to apply any refundable charges to outstanding patient accounts with either Granville Health System or Granville Health Inc., for which I have accepted responsibility as guarantor. I acknowledge review of the HIPAA Notice of Privacy Practices.

_____ _____

Patient/Guardian Signature Date

Medicare Secondary Payer Development

Name: _____ Medicare I.D. # _____ Date of Birth: _____

PART 1

1. Do you receive Black Lung benefits? ☐ Yes ☐ No Date began: _____
   Black Lung is primary for claims related to Black Lung only? ☐ Yes ☐ No
2. Do you receive VA benefits? ☐ Yes ☐ No
3. Is this related to: ☐ Work ☐ Accident (Auto) ☐ Third Party Liability

Insurance Name: _____
Address: _____
_____
Name of Insured: _____
I.D. #: _____

If Workman's Compensation, Employer: _____

PART 2

1. Is your Medicare primary? ☐ Yes ☐ No
2. Is Medicare based on: ☐ Age ☐ Disability ☐ End Stage Renal Disease

AGE/DISABILITY:

1. Are you or your spouse working? ☐ Yes ☐ No
   If yes, are you: ☐ Full Time ☐ Part Time If no, date of retirement: _____

Employer: _____ Number of Employees: _____
Insurance: _____
Address: _____
_____

Policy Holder: _____ Date of Birth *(Policy Holder)* _____
I.D. # _____ Group #: _____

END STAGE RENAL DISEASE:

1. How long have you had End Stage Renal Disease?: _____

Are you in 30 month coordination period? ☐ Yes ☐ No

Do you have Group Coverage: ☐ Yes ☐ No
Insurance: _____
Address: _____

I.D. # _____

Signature: _____ Date: _____

Revised 02/03