Granville HEALTH SYSTEM
Quality Care...Close To Home

Granville Health System, Physician Practices

Patient Registration/Consent Form

Patient Centered Medical Home

PREFERRED PHARMACY INFORMATION

(Please print clearly, all information requested below)

PHARMACY: | **Phone Number:**

PATIENT INFORMATION

Last Name | **First** | **MI**

PHONE CONTACTS

Home # | **Work #** | **Cell #**

SSN: | **Sex:** ☐ Male ☐ Female | **Birth Date:**

Address 1:

Address 2:

Marital: ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced

Employment: ☐ Full Time ☐ Part Time ☐ Self ☐ Not ☐ Retired ☐ Military

City: | **State:**

Zip Code:

Preferred E-Mail:

(PCP) Primary Care Provider/Physician:

Name of Practice/Office/Group: | **Phone #:**

Race:
☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander
☐ Black/African ☐ American Indian/Alaska native ☐ White
☐ More than one race

Ethnicity:
☐ Hispanic ☐ Non-Hispanic
☐ Choose not to report

Preferred Language:
☐ English ☐ Spanish ☐ Other: _____

Preferred method of contact with you:
☐ Phone ☐ E-Mail ☐ My Health Electronic Portal

Learning Preference:
☐ Visual ☐ Voice ☐ Read

Dominant hand:
☐ Right ☐ Left ☐ Both

INSURANCE INFORMATION

(Please Provide Your Insurance Card to the Receptionist for Copying)

I have ☐ PRIMARY Insurance ☐ SECONDARY Insurance

I ☐ Have my Insurance card(s) today
I ☐ DO NOT have my Insurance card(s) today

☐ I DO NOT have Insurance and understand that a SELF-PAY pre-payment may be required

I am ☐ insured by a policy in my name (I am Subscriber)
I am ☐ insured by a policy in someone else's name (I'm NOT Subscriber)

Subscribers name on card (If other than you) | Subscriber Date of Birth:

Relationship to Guarantor:
☐ Self ☐ Spouse ☐ Child ☐ Other

WORKER'S COMPENSATION CLAIM INFORMATION

Employer (Company) Name: | Supervisor: | Phone Number:

Claim #: | Workers Comp. Insurance Carrier: | Date of injury:

EMERGENCY CONTACTS

(Local friend or relative not living at same address)

1st Emergency Contact:	Relationship to Patient:	Address:	Home Phone #:	Cell or Work #:
2nd Emergency Contact:	Relationship to Patient:	Address:	Home Phone #:	Cell or Work #:

The information provided by me above, is true and accurate to the best of my knowledge. I hereby authorize the Medical Provider(s) and/or staff member(s) of Granville Health System's Outpatient Practices to administer any treatment, medical or surgical, considered necessary or advisable, to diagnose and/or treat my condition(s). The diagnostic/treatment process may require/include radiological and/or laboratory testing, administration of local anesthesia and/or the administration of medications. I authorize the release of my personal health information to my active insurance carrier(s) for the sole purpose of determining payment by said carrier(s) for covered services rendered by Granville Health System. I authorize and request payment by my insurance carrier, on my behalf, to Granville Health System, for any/all covered services provided to me. I also fully understand and assume full responsibility for any unpaid balances 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 that I have reviewed and understand the Health Information Portability and Accountability Act (HIPAA) Notice of Privacy Practices. I hereby provide Granville Health System permission to use my mobile phone number to communicate with me regarding my treatment, services rendered and or scheduling by live or recorded means. By providing Emergency Contact information, you are giving authorizing Granville Health System staff to notify the contact and advise them of your location only unless you directed otherwise. Granville Physician Practices WILL NOT disclose or share any of your personal medical information without your separate consent.

_____ _____

Patient / Guardian Signature *Today's Date*

Granville
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HIPAA Release Form

Medical Information Release Form – HIPAA

Patient Full Name: _____ Date of Birth: _____

Release of Information

☐ I authorize the release of information including the diagnosis, records of examination rendered to me, and claims information. This information may be released to:

- ☐ Spouse: _____
- ☐ Child(ren): _____
- ☐ Other: _____

☐ Information is not to be released to anyone.

This release of information will remain in effect until terminated by me in writing.

Messages

Please call: ☐ My Home ☐ My Work ☐ My Cell Number: _____

If unable to reach me:

- ☐ you may leave a detailed message
- ☐ please leave a message asking me to return your call
- ☐ other: _____

The best time to reach me is *(day)* _____ between *(time)* _____

_____ _____

Patient or Legal Representative Signature Date

_____ _____

Print Name Relationship (if signed by person other than the patient)

Granville Primary Care
Butner-Creedmoor

CANCELLATION AND NO SHOW POLICY STATEMENT

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours' notice. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours' notice, we may be unable to offer that time-slot to other patients.

- Office appointments which are cancelled with less than 24 hours notification and patient "no-shows", may be subject to the following cancellation fee schedule:
    - **First missed office appointment:**
        - **No charge as courtesy.**
    - **Second missed office appointment:**
        - **$15 fee will be billed to the patient's account.**
    - **Third and subsequent missed office appointment:**
        - **$25 fee will be billed to the patient's account.**

- The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

- We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Patient's requests for waivers of fees may be submitted to the Practice Manager for review and consideration.

- Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to Maggie Glenn, Practice Manager (919) 575-6103.

Name: _____

Signature: _____

Date: _____