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	PHONE CONTACTS: Home #	Work #	Cell #
First / MI	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 ______________________

Patient Information:

Granville Surgery Clinics
102 C Professional Park Dr.
Oxford, NC 27565

Patient Name: ______________________________ DOB: ________________________
Primary Care Provider: ____
Phone Number ____

Could you be pregnant? ☐ YES/How many months?_____ ☐ NO
Do you have a living will? ☐ YES ☐ NO
Do you have any metal implants? ☐ YES/ Where? __________ ☐ NO
Have you had a flu vaccination? ☐ YES ☐ NO

Medical History:

___ AIDS	___ COPD	___ Heart disease	___ Pacemaker/Defibrillator
___ Allergic rhinitis	___ Cataracts	___ Hepatitis	___ Liver disease
___ Alcoholism	___ Chemical Dependency	___ Hernia	___ Pneumonia
___ Asthma	___ Depression	___ High Cholesterol	___ Prostate problems
___ Anemia	___ Diabetes	___ High blood pressure	___ Seizures
___ Anorexia	___ Earache	___ HIV	___ Sinus disease
___ Appendicitis	___ Emphysema	___ Kidney stones/disease	___ Sleep Apnea
___ Arthritis	___ Fibromyalgia	___ Leg ulcers	___ Strep throat
___ Bleeding disorder	___ Glaucoma	___ Liver disease	___ Stroke
___ Breast lumps	___ Gout	___ Heart murmur	___ Transfusion
___ Bronchitis	___ GERD	___ Migraines	___ Tuberculosis
___ Cancer: ________	___ Hearing loss	___ Multiple sclerosis	___ Psychiatric Care
___ Thyroid Disease	___ Renal failure	___ Stomach ulcers	___ Sickle Cell Anemia

Other: ____

Allergies/Contraindications:

____

____

Family History: (Please check all that apply to your family members):

	Mother	Father	Sister	Brother	Mother's Parents	Father's Parents
Allergies	____	____	____	____	____	____
Asthma	____	____	____	____	____	____
Bleeding disorder	____	____	____	____	____	____
Cancer	____	____	____	____	____	____
Cystic fibrosis	____	____	____	____	____	____
Diabetes	____	____	____	____	____	____
Heart disease	____	____	____	____	____	____
High blood pressure	____	____	____	____	____	____
Sinus disease	____	____	____	____	____	____
Stroke	____	____	____	____	____	____

Other: ____

SOCIAL HISTORY:

Please describe your current tobacco use:

☐ Smoker, current status unknown ☐ Light tobacco smoker ☐ Heavy tobacco smoker ☐ Current every day smoker
☐ Current some day smoker ☐ Former smoker ☐ Never smoker ☐ Unknown if ever smoked

Do you drink alcoholic beverages? ☐ Yes ☐ No

Have you ever used any illicit drugs? ☐ Yes ☐ No

Review of symptoms: (Check any of the following which you have now or have experienced in the past):

General: ☐Normal
- ❑ Chills
- ❑ Fatigue
- ❑ Fever
- ❑ Nausea
- ❑ Night Sweats
- ❑ Weight Gain
- ❑ Weight Loss

MEN ONLY: ☐Normal
- ❑ Erection Difficulty
- ❑ Penis Discharge
- ❑ Testicle Lumps
- ❑ Testicular Pain

Psychiatric: ☐Normal
- ❑ Depression
- ❑ Schizophrenia
- ❑ Suicide Attempt

Urinary: ☐Normal
- ❑ Blood in Urine
- ❑ Frequent Urination
- ❑ Incontinence
- ❑ Kidney Stones
- ❑ Pain/Burning on Urination
- ❑ Urine Leakage

Skin: ☐Normal
- ❑ Change in Moles
- ❑ Dryer Skin
- ❑ Hair Loss
- ❑ Hives
- ❑ Itching/Rash
- ❑ Non-healing sores

Respiratory: ☐Normal
- ❑ Chronic Cough
- ❑ Excessive Sleepiness
- ❑ Spitting Up Blood
- ❑ Snoring
- ❑ Wake up Feeling Unrested
- ❑ Wheezing

Cardiovascular: ☐Normal
- ❑ Chest Pain
- ❑ Murmur
- ❑ Palpitations
- ❑ Shortness of Breath
- ❑ Swelling of Ankles

GI: ☐Normal
- ❑ Abdominal Pain
- ❑ Bloating
- ❑ Change in Bowels
- ❑ Changes in Stool
- ❑ Constipation
- ❑ Diarrhea
- ❑ Indigestion
- ❑ Nausea or Vomiting
- ❑ Vomiting Blood
- ❑ Rectal Bleeding
- ❑

Allergy: ☐Normal
- ❑ Hay Fever
- ❑ Immunosuppressive Drugs
- ❑ Immune Therapy

HEENT: ☐Normal
- ❑ Bleeding Gums
- ❑ Choking Sensation
- ❑ Clouded Vision
- ❑ Difficulty Swallowing
- ❑ Dizziness/Vertigo
- ❑ Double Vision
- ❑ Dry Eyes
- ❑ Dry Mouth
- ❑ Ear Drainage
- ❑ Ear Pain
- ❑ Hearing Loss
- ❑ Hoarseness
- ❑ Lumps in Neck
- ❑ Mouth Sores
- ❑ Nose Bleeds
- ❑ Oral Ulcers
- ❑ Painful Swallowing
- ❑ Reflux
- ❑ Ringing in the Ears
- ❑ Sinus Congestion
- ❑ Snoring
- ❑ Sore Throat
- ❑ Vertigo
- ❑ Vision Changes

WOMEN ONLY: ☐Normal
- ❑ Abnormal PAP
- ❑ Bleeding between Periods
- ❑ Breast Mass
- ❑ Extreme Menstrual Pain
- ❑ Irregular Periods
- ❑ Vaginal Discharge

Endocrine: ☐Normal
- ❑ Hand Size Changes
- ❑ Heat/Cold Intolerant
- ❑ Excessive Thirst
- ❑ Excessive Hunger
- ❑ Shoe Size Changes

Neurological: ☐Normal
- ❑ Dizziness
- ❑ Fainting
- ❑ Headache
- ❑ Memory Loss
- ❑ Numbness/Tingling
- ❑ Seizures
- ❑ Weakness

Musculoskeletal: ☐Normal
- ❑ Back Pain
- ❑ Muscle Weakness
- ❑ Joint Pain
- ❑ Joint Swelling

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

Surgical History: **DATE:**

Medications: Did you bring a list of your medications? If yes, please give to nurse. If no, please fill out below.

PEDIATRIC PATIENTS ONLY:

Was your child born premature? ☐Yes ☐No if yes, how many weeks? ___________

What was your child's birth weight? __________

Has your child ever needed as breathing tube or ventilator? ☐Yes ☐No

Does your child use an Apnea monitor? ☐Yes ☐No

Are your child's vaccinations up to date? ☐Yes ☐No

Does your child have any congenital health problems? ☐Yes ☐No

Did your child have any problems during delivery? (Please list)

____

____

WOMEN ONLY:

Date of Last Menstrual Period _______________

Age menstrual periods started __________

Do you still have regular periods? ☐Yes ☐No

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? ☐Yes ☐No

If so, for how long? _______________

Do you, or did you ever, take hormone replacement? ☐Yes ☐No

If so, for how long? _______________

Date of last Pelvic exam _______________

Date of last Mammogram _______________

Do you perform a self-breast exam? ☐Yes ☐No

Menstrual problems? Please describe below

____

____

Nursing Assistant: BP: ___/___ Weight (kg):_____ Height (in):_____ Pulse:______ Temp:_______ Resp:_____

Pain: 0 1 2 3 4 5 6 7 8 9 10

GHI SPECIALIST PRACTICES
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 for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours' notice, we are 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:
        - $25 fee will be billed to the patient's account.
    - Third and subsequent missed office appointment:
        - $50 fee will be billed to the patient's account.

- Procedure cancellations require 3-business day advance notice. Procedure cancellations with less than 3 days' notice and all procedure "no shows" may be subject to a $75.00 cancellation fee.

- 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 Director, Physician Practices 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 the Director, Physician Practice (919) 690-3180.

Please sign that you have read understand and agree to this Cancellation and No show Policy.

_________________________________ _________________________

Patient Name (Please Print) Date of Birth

_________________________________ _________________________

Signature of Patient or Patient Representative Date

Granville ENT
Phone: (919) 692-0003 Fax: (919) 692-0004

Granville Surgical Associates
Phone: (919) 603-0368 Fax: (919) 603-0842

Granville Urology Associates
Phone: (919) 690-0435 Fax: (919) 690-3430

102 Professional Park Drive, Suite C
Oxford, North Carolina 27565

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: ____

Medical Record # ____________________ **Date of Birth:** ____________________

☐ I authorize ______________________________ to **RELEASE** information for patient care to Granville ENT, Granville Surgical Associates or Granville Urology Associates to the address listed above.

☐ I authorize ______________________________ to **OBTAIN** information for patient Care from:
☐ Wade McClain, DO ☐ Shane Hodge, MD ☐ Naveen Kumar, MD ☐ Joseph Zola, MD

The specific information includes the following dates of service: ____________________

PURPOSE OF THIS RELEASE: *(Check appropriate boxes and include other information where indicated.)*
☐ Continued Medical Care ☐ Legal ☐ Insurance ☐ Personal Use

INFORMATION TO BE RELEASED/OBTAINED *(Check appropriate boxes and include other information where indicated.)*
☐ Comprehensive Record ☐ Laboratory Results ☐ Office Visit Note
☐ Immunization Records ☐ Radiology Reports ☐ Operative Report/Procedure Note
☐ All ☐ Other: ____________________

I hereby authorize the use and/or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. NO individual has coerced me into signing this authorization, and I am providing this authorization under my own free will. I understand that once this information is received by the authorized organization or person, then it may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws. I understand that the person(s) or organization(s) authorized to make the requested use and/or disclosure may not condition treatment, payment, enrollment or eligibility for benefits, on my executing this authorization.

I acknowledge that I have the right to revoke this authorization. I understand that my revocation must be in writing. I also understand that my revocation will be valid except to the extent that the person(s) or organization(s) authorized to make the requested use and/or disclosure have taken action in reliance of this authorization, or if this authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself. This authorization will expire on the following date: ______________________________.

______________________________ ____________________
Patient 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

Medical Information Release Form-HIPAA

Patient's Full Name: ________________________ **Date of Birth:** ___/___/______

Release of Information

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

[ ] Spouse____

[ ] Child(ren) ______________________________________

[ ] Parent/Guardian__________________________________

[ ] 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: [ ] Home __________________ [ ] Work ___________________________

or [ ] Cell ______________________

If unable to reach me:

[ ] You may leave a detailed message.

[ ] Please leave a message asking me to return your call.

Signed: ____________________________________ Date: ____/___/______

Witness: ____________________________________ Date: ____/___/______

Granville

PATIENT RIGHTS AND RESPONSIBILITIES

As an adult patient, or the parent or guardian of a patient at Granville Health System, you have the right to expect that you will be cared for in a manner that promotes your well-being. In the same way, the staff requires your cooperation to provide your care.

Listed below are the fundamental Patient Rights and Responsibilities identified as consistent with the Mission, Vision and Values of Granville Medical Center and adopted by the Medical Staff and Board of Trustees.

It is the Patient's Responsibility to:

- Give correct and complete information about your health status and health history.
- Ask questions if you do not understand information or instructions.
- Inform your caregivers if you do not intend to or cannot follow the treatment plan.
- Accept health consequences that may occur if you decide to refuse treatment or instructions.
- Cooperate with your caregivers.
- Respect the rights and property of other patients.
- Tell your caregivers of any medications you brought from home.
- Report any changes in your health status to your caregivers. You, the Patient have the right to:

You, the Patient have the right to:

- Respect and Privacy
- Respect in a caring and safe environment
- Personal privacy and confidentiality of your health information
- Quality Care
- Proper evaluation and treatment
- Proper pain assessment and pain management
- Be free from restraints, except when needed to protect you or others from harm. • Be free from abuse.
- Have access to protective services.
- Spiritual services upon request
- Contact your caregivers or a supervisor to have your concerns heard and/or resolved if possible.
- Information & Communication
- Know the names and roles of those caring for you.
- Communicate with your caregivers in a language or method you can understand.
- Have your personal physician and a person of your choice notified when you are admitted to the hospital.
- Communicate with people outside the hospital by way of visitors, phone and mail, except when doing so would interfere with your care. Any restrictions will be explained to you.
- Be informed about your health status, recommended treatments, options, risks and benefits.
- Information about the costs of your care and payment methods.
- Review and receive a copy of your medical record, subject to state law and hospital policy.
- Make Decisions
- Be involved with your care through discussions with your caregivers.
- Be informed of benefits and risks of your treatment options and agree to or refuse a course of action.
- Designate a support person (or persons) of your choosing to be involved in your care when appropriate. You may restrict access of your support person or visitors at any time. University of Utah Hospitals and Clinics will

not restrict your support person(s) or visitor based upon their race, color, culture, language, ethnicity, religion, sex, sexual orientation, gender identity or expression, socioeconomic status, age, national origin, physical or mental disability, and/or veteran status.

- Direct your care through an Advance Directive. Advance Directives are legal forms which state your choices about the care you want to receive in serious health situations. Advance Directives are also used to name someone to make decisions for you if you cannot speak for yourself. At your request, we will help you create an Advance Directive.
- Request a discharge plan evaluation. A designated support person (or persons) acting on your behalf can also request a discharge plan evaluation.
- Choose whether or not to take part in research studies and to have studies explained to you before you decide. Other care will continue regardless of your decision to take part in research studies.
- Seek an alternate doctor or ask for a second opinion.