Granville HEALTH SYSTEM

Physician Practices
Patient Registration/Consent Form

PREFERRED PHARMACY INFORMATION	
PHARMACY:	**Phone Number:**

PATIENT INFORMATION: PLEASE PRINT CLEARLY				
Last:		**Home #**	**Cell #**	**Work #**
First:	**MI**	**SSN:**	**Sex:** ☐ Male ☐ Female	**Birth Date:**
Address 1: **Address 2:**		**Employment:** ☐ Full Time ☐ Part Time ☐ Self ☐ Not ☐ Retired ☐ Military		**Marital Status:** ☐ Single ☐ Separated ☐ Married ☐ Widowed ☐ Divorced
City:	**St:** **Zip:**	**(PCP) Primary Care Provider:**		**Name of Practice/Office:**
E-Mail:				
Race: ☐ Asian ☐ Native Hawaiian ☐ White ☐ Other Pacific Islander ☐ Black/African American ☐ Indian/Alaska Native ☐ 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 ☐ Electronic Health Portal		Learning Preference: ☐ Visual ☐ Voice ☐ Read		Dominant hand: ☐ Right ☐ Left ☐ Both

INSURANCE INFORMATION: PLEASE PROVIDE INSURANCE CARD TO FRONT DESK TO SCAN		
I am ☐ insured by a policy in my name (I'm the Subscriber) I am ☐ insured by a policy in someone else's name (I'm NOT the Subscriber)	Subscriber's name on card (If other than yourself)	Subscriber Date of Birth:
Relationship to Guarantor: ☐ Self ☐ Spouse ☐ Child ☐ Other	☐ **I DO NOT** have insurance and understand a SELF-PAY pre-payment may be required	I have ☐ PRIMARY Insurance ☐ SECONDARY Insurance

EMERGENCY CONTACTS			
Emergency Contact:	Relationship to Patient:	Address:	Phone #:
Emergency Contact:	Relationship to Patient:	Address:	Phone #:

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 GHS. I authorize and request payment by my insurance carrier, on my behalf, to GHS, 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 GHS, pursuant to its agreement with Granville Health Inc., to apply any refundable charges to outstanding patient accounts with either GHS 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 GHS 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 GHS 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**

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 HEALTH SYSTEM

Granville Physician Practices

Consent for Verbal Communication and Medical Treatment

Patient Name: _____ **DOB:** _____

Verbal Communication:

I authorize the release of information for verbal communication about my care including appointment times to the following:

Spouse: _____

Child: _____

Other: _____

☐ My Health information is not to be released to anyone

Messages:

Please call: _____ If you are unable to reach me:

☐ You may leave a detailed message
☐ Please leave a message asking to return your call
☐ Do not leave a message

_____ _____ _____

Signature Witness Date

Minors:

I authorize Granville Physician Practices to treat my child_____, DOB: _____ as medically necessary during my absence. I also grant permission to release any medical information acquired in the course of my child's examination or treatment, to any facility including other physicians, laboratory, hospital, or ancillary providers to which my child may need to be referred. I also authorize release of am medical information determined in the course of my child's examination or treatment required to process medical claims, to my insurance carrier.

_____ _____

Authorized Caretaker (Print) Relationship

_____ _____

Authorized Caretaker (Print) Relationship

_____ _____

Parent/Guardian Signature Date

This Consent will remain in effect until terminated in writing.

Granville Specialty Practices
102/103 Professional Park Dr.
Oxford, NC 27565

Patient Information:

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 the symptoms you are having related to today's visit)

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.

Please List Physicians who are currently seeing or have seen in the last year

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

PATIENT RIGHTS & RESPONSIBILITIES

1. A patient has the right to respectful care given by competent personnel.
2. A patient has the right, upon request, to be given the name of his attending physician, the names of all other physicians directly participating in his/her care, and the names and functions of other health care persons having direct contact with the patient.
3. A patient has the right to every consideration of his/her privacy concerning his/her own medical care program. Case discussion, consultation, examination, and treatment are considered confidential and shall be conducted discreetly.
4. A patient has the right to have all records pertaining to his/her medical care treated as confidential except as otherwise provided by law or third-party contractual arrangements.
5. A patient has the right to know what facility rules and regulations apply to his conduct as a patient.
6. The patient has the right to expect emergency procedures to be implemented without unnecessary delay.
7. The patient has the right to good quality care and high professional standards that are continually maintained and reviewed.
8. The patient has the right to full information in layman's terms, concerning his/her diagnosis, treatment and prognosis, including information about alternative treatments and possible complications. When it is not possible or medically advisable to give such information to the patient, the information shall be given on his/her behalf to the patient's designee.
9. Except for emergencies, the physician must obtain the necessary informed consent prior to the start of any procedure or treatment, or both.
10. A patient has the right to be advised when a physician is considering the patient as a part of a medical care research program or donor program. Informed consent must be obtained prior to the actual participation in such program and the patient or legally responsible party, may, at any time, refuse to continue in any such program to which he/she has previously given informed consent. An Institutional Review Board (IRB) may waive or alter the informed consent requirement if it reviews and approves a research study in accord with federal regulations for the protection of human research subjects including U.S. Department of Health and Human Services (HHS) regulations under 45 CFR Part 46 and U.S. Food and Drug Administration (FDA) regulations under 21 CFR Parts 50 and 56. For any research study proposed for conduct under a FDA "Exception form Informed Consent Requirements for Emergency Research" or a HHS "Emergency Research Consent Waiver" in which informed consent is waived but community consultation and public disclosure about the research are required, any facility proposing to be engaged in the research study also must verify that the proposed research study has been registered with the North Carolina Medical Care Commission. When the IRB reviewing the research study has authorized the start of the community consultation process required by the federal regulations for emergency research, but before the beginning of that process, notice of the proposed research study by the facility shall be provided to the North Carolina Medical Care Commission.

    The notice shall include: * the title of the research study; *a description of the research study, including a description of the population to be enrolled; *a description of the planned community consultation process, including currently proposed meeting dates and times; *an explanation of the way that people choosing not to participate in the research study may opt out; and *contact information including mailing address and phone number for the IRB and the principal investigator.

    The Medical Care Commission may publish all or part of the above information in North Carolina Register, and may require the institution proposing to conduct the research study to attend a public meeting convened by a Medical Care Commission member in the Community where the proposed research study is to take place to present and discuss the study or the community consultation process proposed.
11. A patient has the right to refuse any drugs, treatment or procedure offered by the facility, to the extent permitted by law, and the physician shall inform the patient of his/her right to refuse any drugs, treatment or procedures and of the medical consequences of the patient's refusal of any drugs, treatment or procedure.
12. A patient has the right to assistance in obtaining consultation with another physician at the patient's request and expense.
13. A patient has the right to medical and nursing services without discrimination based upon race, color, religion, sex, sexual orientation, gender identity, national origin or source of payment.

Granville
HEALTH SYSTEM

PATIENT RIGHTS & RESPONSIBILITIES

14. A patient who does not speak English or is hearing impaired shall have access, when possible, to a qualified medical interpreter (for foreign language or hearing impairment) at no cost, when necessary and possible.
15. The facility shall provide a patient or patient designee, upon request, access to all information contained in the patient's medical records. A patient's access to medical records may be restricted by the patient's attending physician. If the physician restricts the patient's access to information in the patient's medical record, the physician shall record the reasons on the patient's medical record. Access shall be restricted only for sound medical reason. A patient's designee may have access to the information in the patient's medical records even if the attending physician restricts the patient's access to those records.
16. A patient has the right to not be awakened by hospital staff unless it is medically necessary.
17. The patient has the right to be free from needless duplication of medical and nursing procedures.
18. The patient has a right to medical and nursing treatment that avoids unnecessary physical and mental discomfort.
19. When medically permissible, a patient may be transferred to another facility only after he/she or his/her next of kin or other legally responsible representative has received complete information and an explanation concerning the needs for alternatives to such a transfer. The facility to which the patient is to be transferred must first have accepted the patient for transfer.
20. The patient has the right to examine and receive a detailed explanation of his/her bill.
21. The patient has a right to full information and counseling on the availability of known financial resources for his/her health care.
22. A patient has the right to expect that the facility will provide a mechanism whereby he/she is informed upon discharge of his/her continuing health care requirements following discharge and the means for meeting them.
23. A patient shall not be denied the right of access to an individual or agency who is authorized to act on his/her behalf to assert or protect the rights set out in this Section.
24. A patient, or when appropriate, the patient's representative has the right to be informed of his/her rights at the earliest possible time in the course of his hospitalization.
25. The patient, and when appropriate, the patient's representative has the right to have any concerns, complaints and grievances addressed. Sharing concerns, complaints and grievances will not compromise a patient's care, treatment or services. If the patient has a concern, complaint, or grievance, he/she may contact the Nurse, the Nurse Manager, or call the Quality/Risk Department at 919-690-2147. If the patient issues are not satisfactorily addressed while the patient remains hospitalized, the investigation will continue. The intent is to provide the patient a letter outlining the findings of the investigation. The patient has the right to directly contact the North Carolina Department of Health and Human Services (State Survey Agency) or the Joint Commission on Accreditation of Healthcare Organization.

PATIENT RESPONSIBILITIES

- Patients, and their families when appropriate, are responsible for providing correct and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to their health.
- Patients and their families are responsible for asking questions when they do not understand their care, treatment, and service or what they are expected to do.
- Patients and their families are responsible for following the care, treatment, and service plans that have been developed by the healthcare team and agreed to by the patient.
- Patients and their families are responsible for the outcomes if they do not follow the care, treatment, and service plan.
- Patients and their families are responsible for following the hospital's rules and regulations.
- Patients and their families are responsible for being considerate of the hospital's staff and property, as well as other patients and their property.
- Patients and their families are responsible to promptly meet any financial obligation agreed to with the hospital.

Granville
HEALTH SYSTEM