FAIRGROVE PRIMARY HEALTH - PATIENT REGISTRATION FORM

PATIENT INFORMATION:

DATE_____/_____/_____

NAME: LAST_____ FIRST _____ MIDDLE INITIAL _____

CIRCLE ONE: MR. MRS. MISS. MS. JR. NICKNAME OR PREVIOUS NAME: _____ (IF APPLICABLE)

MAILING ADDRESS _____

STREET ADDRESS (IF DIFFERENT FROM MAILING) _____

CITY _____ STATE _____ ZIP_____ HOME PHONE (_____) _____ - _____

CELL PHONE (_____) _____ - _____ WORK PHONE (_____) _____ - _____ EXT. _____

APPOINTMENT AND HEALTH REMINDERS:

Is it okay to leave a message regarding your appointment reminder? □ Yes □ No

Phone Preferred Phone: _____

Who is your Primary Care Provider? _____

DATE OF BIRTH _____/_____/_____ **SOCIAL SECURITY #** _____ / _____ / _____

SEX □ F □ M □ Transgender If transgender, please select one: □ Male to Female or □ Female to Male

MARITAL STATUS: □ SINGLE □ DIVORCED □ LEGALLY SEPARATED □ PARTNER

□ MARRIED (SPOUSE NAME _____) □ WIDOWED

EMPLOYMENT STATUS: EMPLOYER NAME _____

ADDRESS _____

□ FULL TIME □ NOT EMPLOYED □ RETIRED □ PART TIME □ SELF EMPLOYED □ ACTIVE MILITARY □ DISABLED

STUDENT STATUS: □ FULL TIME □ PART TIME □ NOT A STUDENT

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: (_____) _____ - _____

INSURANCE INFORMATION: Please provide us with your insurance card so that we can scan a copy into your medical record.

RESPONSIBLE PARTY: (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 □ Transgender

EMPLOYER NAME _____ ADDRESS _____

ADVANCE DIRECTIVE:

Do you have a Living Will or an Advance Directives document? Please check all that apply

□ NO □ DNR (Do Not Resuscitate) □ POA (Power of Attorney) □ Living Will

If not, our staff will be glad to provide you with information. If you have already signed a living will or advanced directive form, please submit a copy to this office for our records.

□ I wish to receive Advanced Directive Information □ FOR CLINIC USE ONLY: Information given to Patient

□ I do not wish to receive Advanced Directive Information

Please note: If you have a medical emergency while receiving care, treatment or services at Fairgrove Primary Health, life-saving actions will be started even if you have an advanced directive.

If you would like to access your Personal Health Record (PHR) online, please check yes below and provide us with your email address.

□ **YES** □ **NO** **Email Address:** _____

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

RACE (choice one or more): □ African American □ American Indian or Alaska Native □ Caucasian/White

□ Asian (choose one or more)

O Asian Indian O Chinese O Filipino O Japanese
O Korean O Vietnamese O Other Asian

□ Native Hawaiian or Pacific Islander (choose one or more)

O Native Hawaiian OSamoan OGuamanian/Chomorro O Other Pacific Islander

ETHNICITY (chose one): □ Non-Hispanic/Latino

□ Hispanic/Latino (choose one or more)

O Mexican/Mexican American/Chicano O Puerto Rican
O Cuban O Another Hispanic Latino or Spanish Origin

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

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:_____

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

Name	Phone	Relationship to Patient

My signature below signifies that the above information is true to the best of my knowledge.

(PATIENT SIGNATURE) (DATE)

(RESPONSIBLE PARTY SIGNATURE) (RELATIONSHIP) (DATE)

Fairgrove Primary Health
3412-A Graystone Place
Conover, NC 28613
828-326-2145 (phone)
828-326-2922 (fax)

CONSENT FOR MEDICAL TREATMENT & RELEASE OF INFORMATION

Consent to Medical Treatment: I do 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 acknowledge that no guarantees have been made to me as to the result of examination or treatment in this clinic.
Consent for Rx History: I agree to allow Fairgrove Primary Health to access my prescription history from external sources.
Consent for photography: I understand that from time to time Fairgrove Primary Health may photograph me while care is being provided. I understand that these photographs 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 employees or medical staff.

Authorization to Release Information: My signature below hereby authorizes Fairgrove Primary Health to release any information to or from ALFA (Advancing Life Fighting AIDS) and any other physician, health care provider, or community agency that provides or coordinates treatment of care, to whom the undersigned may be referred and to his/her insurance company(s). I hereby authorize regulatory and accrediting agencies to review my medical record during surveys or inspections. Information may be exchanged verbally, by fax, electronically, or mail. By signing this authorization to release information, I understand that my medical information (including HIV status) may be released to other agencies to which I may be referred. I also understand that such medical information will only be released when necessary for receiving appropriate care. This authorization to release information will expire twelve (12) months from the date of signing. I understand it is my right to revoke this authorization at any time, except to the extent that action based on this authorization has been taken. I also understand refusal in no way jeopardizes my right to obtain present or future services.
In an effort to improve my care, Fairgrove Primary Health 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”. Information to be provided may include, but is not limited to, psychotherapy notes, diagnoses, treatments, procedures, and other pertinent medical information. Psychotherapy notes are defined as notes recorded by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session.

Assignment of Benefits: My signature below acknowledges that it is my responsibility to understand my insurance benefits, and I further agree to pay and be responsible for any services that my insurance company does not pay. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and other health plans to Catawba Valley Medical Center.

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.

Patient Name (print): _____

Date of Birth: _____ Social Security #: _____

Patient Signature: _____ Date: _____

If Minor, Parent/Guardian Signature: _____ Date: _____

Expiration Date: _____

ADMCON

Catawba Valley Medical Center

CONSENT TO ADMISSION, TREATMENT and DIAGNOSTIC SERVICES

I. Consent To Hospital Admission, Medical Treatment, and/or Diagnostic Services

I do voluntarily consent to such diagnostic procedures and hospital care deemed necessary by the attending physician, his assistant or his designated consultants, including testing for Human Immunodeficiency Virus (HIV).

I understand that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the result of examination or treatment in this hospital. I also understand that CVMC is affiliated with various institutions of higher learning in an effort to facilitate clinical education of the next generation of healthcare providers. In accordance with these affiliations, I understand healthcare students supervised by CVMC staff or physicians may observe and/or participate in the delivery of my medical treatment and should I decline, my access to care will not be delayed or otherwise affected. I further understand that physicians and providers practicing at the hospital may not be employed by the hospital. I consent to evaluation/treatment by physicians and providers with the understanding that they may be independent contractors privileged to practice at the hospital, but employed by an entity separate and distinct from the hospital. I have made no assumptions and have drawn no conclusions about the employment status of the physicians and providers caring for me simply because they have provided or will be providing care to me at the hospital.

II. Conditions of Admission, Treatment, and/or Diagnostics

I. **Personal Valuables:** I understand that the hospital maintains a safe and will hold on deposit any money or valuables for which the hospital has issued a safekeeping receipt, and the hospital is not responsible for personal valuables retained in my patient room. Personal valuables include items such as money, dentures, glasses, hearing aids, clothing,jewelry, and books.

2. **Recording or Filming** (to include photographs, video, electronic, or audio media): I understand that from time to time Catawba Valley Medical Center (CVMC) may record or film me while care is being provided (for example, in the Operating Room). I understand that these recordings/filming 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 employees or medical staff.

3. **Release of Information:** I authorize CVMC to release information necessary for external and internal quality improvement activities, including information required by regulatory and accrediting bodies. As described in the Notice of Privacy Practices, CVMC may allow health care providers to have access to my medical information for treatment, payment and health care operations. In an effort to improve my care, CVMC 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".

4. **Assignment of Benefits:** I assign any and all insurance benefits directly to Catawba Valley Medical Center and physician(s) who perform services, otherwise payable to me including medical, surgical benefits, major medical benefits, liability benefits and worker's compensation medical benefits.

5. **Financial Agreement:** I understand and acknowledge that I am responsible for all charges not paid by my insurance plan including, but not limited to, deductibles, co-insurance, co-pays, non-covered take home or self-administered drugs and non-covered services. I agree to be responsible for and pay any services that my insurance does not. I understand that uninsured medication costs may be credited to my account if I qualify for certain benefit programs. I agree to allow Pharmacy Health solutions (PHS) to act as my representative and apply on my behalf for these programs.
   Electronic options available for payment are credit cards, debit cards, and electronic checks. I give CVMC authorization to charge my bank account or debit card on or after this date of service in the amount determined by me. I authorize refunds to my insurance for their overpayments as necessary. All outstanding accounts must be satisfied before I will receive a refund of patient payment.

6. **Authorization to call any number I have provided to CVMC:** I authorize CVMC to call any number that I have provided or any number at which CVMC reasonably believes they can contact me, including calls to mobile, cellular or similar devices for any lawful purpose. I agree to any fee(s) or charge(s) that I may incur for incoming calls from CVMC and/or outgoing calls to CVMC, to or from any such number, without reimbursement from CVMC.

7. **Medicare and Medicaid Patient Certification:** I certify that the information given by me in applying for payment under Medicare (Title XVIII) and/or Medicaid (Title **XIX)** of the Social Security Act is correct. I request and understand that payments of authorized benefits will be made on my behalf to CVMC and physicians providing services.

Catawba Valley Medical Center

ADMCON

CONSENT TO ADMISSION, TREATMENT and DIAGNOSTIC SERVICES

8. **Patient Rights:** Catawba Valley Medical Center strives to protect the rights of each patient.

a. **Access to Care:** Patients have the right to impartial access to medically indicated treatments and can expect to have emergency procedures implemented without delay.

b. **Respect:** Patients have the right to considerate and respectful care given by competent personnel.

c. **Dignity:** Patients have the right to be treated with dignity.

d. **Privacy and Confidentiality:** Patients have the right to expect that any discussion and all written communications pertaining to their care be treated as confidential.

e. **Personal Safety:** Patients have the right to expect reasonable safety precaution be taken, in tenns of practices and the environment in which care is provided. Patients have the right to be free from restraints that are not medically necessary.

f. **Identity:** Patients have the right to know the identity. professional status and relationships of those providing services, including knowing who is primarily responsible for their care.

g. **Information:** Patients have the right to be informed about the outcomes of their care.

h. **Communication:** Patients have the right to verbal and written communications and access to people that are authorized to act on the patient's behalf to assert or protect their rights. When the patient does not undo.!rstand the predominant language of the community or is hearing impaired, access to an interpreter will be provided.

i. **Visitation:** Patients have the right to receive the visitors whom he or she designates. All visitors will enjoy full and equal visitation privileges consistent with patient preferences and a "support person" may be identified by the patient.

j. **Consent:** Patients have the right to informed participation in decisions involving their health care.

k. **Consultation:** Patients have the right to consult with a specialist

l. **Participation in the Plan of Care:** Patients have the right to participate in the development, implementation and revision of his/her plan of care. Patients may refuse treatment to the extent permitted by law and are informed of the medical consequences of such refusal.

m. **Knowledge of Continuing Care Needs:** Patients may not be transferred to other facilities unless they have received complete explanation of the need for the transfer and the transfer is acceptable to the patient and the other facility.

n. **Comfort:** Patients have the right to quick response directed to optimize pain management.

o. **Financial Explanation:** Patients have the right to request and receive an itemized and detailed explanation of their total bill.

p. **Hospital Rules and Regulations:** Patients have the right to access to the hospital rules and regulations.

q. **Grievances:** Patients have the right to expect that care and services are provided in a timely, reasonable and consistent manner. When a patient issue cannot be resolved promptly by the staff present, the patient has the right to file a formal grievance.

r. **Children and Teens:** Children and teens have the right to make choices and let our staff know how they want to be involved in their care. Children's right to grow, play, learn, rest and feel secure will be respected.

All departments at Catawba Valley Medical Center are licensed and regulated by:
North Carolina Department of Health and Human Services: Division of Health Service Regulation
Acute and Home Care Branch
2717 Mail Service Center, Raleigh, North Carolina 27699-2711
Phone: 919-855-4500 or 1-800-624-3004

The Disability Rights of North Carolina has the power to investigate complaints at any 24-hour behavioral health facility in the state. To contact Disability Rights of North Carolina, please call 1-877-235-4210 or email info@disabilityrightsnc.org

The Joint Commission. whose mission is to monitor healthcare organizations' compliance with patient quality and safety of care standards. If a patient and/or patient's designee wishes, The Joint Commission may be contacted at 800.994.6610 or patientsafctyrcport@jointcommission.org

Medicare patients have the right to submit a complaint regarding quality of care, disagreement with a coverage decision or appeal a perceived premature discharge to Kepro, The Quality Improvement Organization (QIO). Kepro may be contacted at 844.455.8708 or via TTY at 855.843.4776.

If you would like a more detailed description of these patient rights, please ask your nurse, healthcare provider, or call 828-326-3720.

9. **Notice of Privacy Practices:** 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.

Date___ Time_____

Signature of Patient/Legal Representative (Specify Relationship and Explain)

Date_____ **Time**_____

Signature of Witness

Fairgrove Primary Health		
Current Status: *Active*		Policy Number: PO-4
CATAWBA VALLEY HEALTH SYSTEM	Origination:	10/2005
	Last Reviewed:	12/12/2022
	Next Review:	12/12/2025
	Responsible for Content	Director of FPH & CVIDC
	Document Area:	N/A
	Applicability:	☑CVMC ❑CVMG
	Exclusions:	☑No Exclusions

DISCHARGE PATIENT FROM SERVICE

I. POLICY

Patients, staff, and visitors have the right to expect a safe clinic environment free from any form of harassment. CVHS will not tolerate intimidating, disruptive, or violent behavior by or against employees, visitors, patients, their family members and/or significant others.

II. PROCESS

Staff members will immediately notify the Clinical Manager of inappropriate behavior, or if an immediate threat is perceived, contact the CVHS police or call 911. If appropriate, the Clinical Manager will address patients/family members/significant others and request that behavior cease.

Patients can be refused service from FPH for:

1. Communicating any form of harassment to include but not limited to being verbally or physically abusive to employees, visitors, or other patients/family members/significant others in the practice.
2. Threatening employees, visitors, or other patients/family members/significant others in the practice verbally in person, on the telephone, or in writing. This includes communication using the patient portal. (i.e. bomb threats or death threats)
3. Inappropriate sexual advances to employees, visitors, or other patients/family members/significant others in the practice.
4. Creating disturbances in the practice. (i.e. use of profanity, yelling, slamming doors)
5. Falsifying prescriptions.

Name: _____ DOB: _____

Signature: _____

Date: _____

- Any FPH employee that becomes aware of a situation that may warrant a refusal of service should report the incident to the Clinical Manager, Administrator, or Vice President.
- The Clinical Manager will discuss the situation with the employee, Administrator, Vice President, Medical Director, and other healthcare providers, as appropriate, to make a decision regarding refusing service to the patient.
- The patient will be notified via certified letter of a decision to refuse service. Return receipt will be requested.
- The patient will be provided with the reason for refusal of service (i.e. verbally abusive, threatening behavior, etc.) as well as the effective date of termination.
- FPH will inform the patient in the certified letter that the patient's healthcare provider will continue to provide care to the patient in emergency situations for **30** days. Referral information will be provided to the patient allowing them to arrange care with another primary care provider.
- All conflicts and subsequent patient dismissals will be documented in the patient's chart to reflect the details regarding the rationale for discharging the patient.

III. DEFINITIONS

CVHS defines disruptive behavior or violent behavior as a style of interaction between individuals or style of behavior that interferes with or jeopardizes safety, a positive working environment, or the ability of others to provide safe, quality care or otherwise perform their job duties.

Intimidating or disruptive behavior may include overt or passive actions that may include, but are not limited to:

- Active or overt behaviors such as verbal outbursts with or without the use of profanity, belittling remarks, condescending/hostile/degrading remarks, express or implied threats, throwing or breaking equipment/supplies/property, bullying or aggressive behavior, assault, brandishing a weapon or bringing it on CVHS property

IV. RELATED DOCUMENT

- Organizational Policy, Harassment HR-24
- Organizational Policy, Disruptive or Violent Behavior in the Workplace HR-58