

CATAWBA VALLEY MEDICAL GROUP - PATIENT REGISTRATION FORM – PRIMARY AND SPECIALTY CARE

PATIENT INFORMATION:

DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

NAME: LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MIDDLE INITIAL \_\_\_\_\_

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

DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ SEX  F  M  Unknown  Transgender SOCIAL SECURITY # \_\_\_\_/\_\_\_\_/\_\_\_\_

MAILING ADDRESS \_\_\_\_\_

STREET ADDRESS (IF DIFFERENT FROM MAILING) \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ HOME PHONE (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

CELL PHONE (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ WORK PHONE (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ EXT. \_\_\_\_\_

RACE: \_\_\_\_\_ ETHNICITY:  HISPANIC  NON-HISPANIC

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

PATIENT MARITAL STATUS:

SINGLE  DIVORCED  LEGALLY SEPARATED  PARTNER

MARRIED (SPOUSE NAME \_\_\_\_\_)  WIDOWED  UNKNOWN

PATIENT EMPLOYMENT STATUS:

EMPLOYER NAME \_\_\_\_\_

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

APPOINTMENT AND HEALTH REMINDERS:

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

Please choose ONE option for your appointment reminder communication:

Phone Preferred Phone: \_\_\_\_\_ Preferred time:  Morning  Afternoon  Evening

Text Preferred Phone: \_\_\_\_\_ Preferred time:  Morning  Afternoon  Evening

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

I can STOP text reminders at any time by contacting my practice directly and requesting that text appointment reminders to be turned off

Please check any or all the following options to give us permission to send you important health reminders via:

Email- emails are sent to the email address provided in the 'Web Enable/ Patient Portal Access' section of this Form- for the ages indicated

Letter

RESPONSIBLE PARTY / POLICY HOLDER:

(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

EMPLOYER NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_

WEB ENABLE/ PATIENT PORTAL ACCESS

All Patients: By Providing your email address we will be able to send you a patient satisfaction survey after your visit.

Patients age 0-12 and 18 and up: If you would like to access your Personal Health Record (PHR) online, please check yes below and provide us with your email address. Patients age 13-17 do not have Patient Portal access.

Yes  No Email Address: \_\_\_\_\_

**PHARMACY (RETAIL):**

NAME \_\_\_\_\_

LOCATION \_\_\_\_\_

**PHARMACY (MAIL ORDER):**

NAME \_\_\_\_\_

LOCATION \_\_\_\_\_

**PRESCRIPTION REFILLS:**

I understand that Catawba Valley Medical Group may need to access my refill information at all of my pharmacies regarding the prescriptions that I have had filled.  **Yes**  **No**

**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: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Due to our participation in Federal Healthcare Programs, we are required to collect the following information:**

**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

For Specialty Appointments: Who is your Primary Care Provider? \_\_\_\_\_

**INSURANCE INFORMATION:**

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

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

\_\_\_\_\_  
(PATIENT SIGNATURE)

\_\_\_\_\_  
(DATE)

\_\_\_\_\_  
(RESPONSIBLE PARTY SIGNATURE)

\_\_\_\_\_  
(RELATIONSHIP)

\_\_\_\_\_  
(DATE) Rev 8.30.23

**CATAWBA VALLEY MEDICAL GROUP**  
**CONSENT TO TREATMENT AND FINANCIAL AGREEMENT**

**Consent**

I 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 further acknowledge that no guarantees have been made to me as to the result of examination or treatment in this clinic.

**Insurance**

I hereby assign all medical and/or surgical insurance benefits directly to Catawba Valley Medical Group and physician(s) who perform services, otherwise payable to me including, Medicaid, private insurance, other health plans and worker's compensation medical benefits. I understand my insurance will automatically be filed as a courtesy. I understand all insurance co-pays and unmet deductibles are due at time of service.

**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 and non-covered services. I agree to be responsible for and pay any services that my insurance does not.

I understand payment is due at time of service. Options for payment are cash, check, Visa, MasterCard, Discover and American Express. I give CVMG authorization to charge by 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. Unpaid balances will be referred to an outside agency for collection. Nonpayment for Access One Med Card balances will also be referred to an outside agency for collection.

I understand that CVMG also provides an additional payment option for patients whose needs require extended terms to pay balances in full. The AccessOne Med Card allows patients to make monthly payments at a minimal interest rate. Applications for AccessOne are available at the front desk.

I understand that visits to Catawba Valley Urgent Care Saturday Clinic and Catawba Valley Urgent Care - Piedmont will include an additional convenience charge for after-hours service.

**Missed Appointments**

Should you need to cancel or re-schedule an appointment, please contact our office 24 hours in advance or as soon as possible. We are here to serve you, but once three appointments have been missed within a rolling 12 month period, you may be dismissed from the practices of Catawba Valley Medical Group and asked to seek care elsewhere.

**Personal Valuables**

I understand that CVMC/CVMG is not responsible for personal valuables brought into the practice or left in my vehicle.

**Recording or Filming**

Recording or Filming (to include photographs, video, electronic or audio media): I understand that from time to time Catawba Valley Medical Group (CVMG) may record or film me while care is being provided (for example, photo documentation of injuries). I understand that these recordings/films/photos 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 medical staff.

**Release of Information and Notice of Privacy Practices**

I authorize CVMG 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, CVMG 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, CVMG 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".

**I have read the Consent to Treatment and Financial Agreement, I understand, and agree to its terms. 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 Printed Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

X \_\_\_\_\_  
Patient or Responsible Party Signature

\_\_\_\_\_  
Date

 **CATAWBA VALLEY  
MEDICAL GROUP**  
S P E C I A L T Y C A R E

Catawba Valley Cardiology: p - 828.732.5700, f - 828.732.5701  
Catawba Valley Vascular Surgery: p - 828.732.5200, f - 828.732.5201  
Catawba Valley Pulmonology: p - 828.732.5400, f - 828.732.5401  
Catawba Valley Vascular Surgery - Horizon: p: 828.732.7500, f - 828.732.7501  
Catawba Valley Foot & Ankle Center: p - 828.732.5530, f - 828.732.5531  
Catawba Valley Surgery & Cancer Center.: p - 828.732.7400, f - 828.732.7401  
Catawba Valley Neurology: p - 828.732.7600, f - 828.732.7601

**MEDICAL RECORD RELEASE FORM**

PATIENT NAME: \_\_\_\_\_  
LAST FIRST MIDDLE MAIDEN

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

**I HEREBY AUTHORIZE CATAWBA VALLEY MEDICAL GROUP (PLEASE CHECK ONE):**

TO OBTAIN MY RECORDS FROM: \_\_\_\_\_

FAX # \_\_\_\_\_ PHONE# \_\_\_\_\_ ADDRESS \_\_\_\_\_

TO RELEASE MY RECORDS TO: \_\_\_\_\_

FAX # \_\_\_\_\_ PHONE# \_\_\_\_\_ ADDRESS \_\_\_\_\_

**FOR THE PURPOSE OF (PLEASE CHECK ONE):**

TRANSFER OF CARE  
 OTHER (LIST REASON) \_\_\_\_\_

**MEDICAL RECORDS FROM THE FOLLOWING TIME PERIOD ARE TO BE RELEASED:**

FROM \_\_\_\_\_ TO \_\_\_\_\_  
Date Date

**INFORMATION REQUESTED INCLUDES (PLEASE CHECK ALL THAT APPLY):**

ALL RECORDS  
 DRUG, ALCOHOL TREATMENT RECORDS  
 PSYCHIATRIC TREATMENT RECORDS  
 AIDS (acquired immunodeficiency syndrome) or infection with HIV (human immunodeficiency virus)  
 OTHER: \_\_\_\_\_

**Right to terminate or revoke authorization:** This authorization shall expire (60) days from this date. You may revoke or terminate this authorization by submitting a written revocation to our practice.

**Potential for re-disclosure:** I understand that once the authorized organization or person receives this information, then this information may be subject to re-disclosure. It may not be possible to ensure your right to protection of the privacy of this information once our practice discloses it to another party.

**Effect of refusing authorization:** If you refuse to sign this authorization, our practice will not deny you any treatment except research-related treatment or treatment that you have requested for the purpose of disclosure to others.

**Rights of the individual:** You have the right to contact and request that your information be protected from anyone that you release your health information to.

\_\_\_\_\_  
Signature of Patient or Patient's Legal Representative and Relationship to the Patient

\_\_\_\_\_  
Date

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