CATAWBA VALLEY MEDICAL GROUP - PATIENT REGISTRATION FORM – SPECIALTY CARE

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. _____

DATE OF BIRTH _____/_____/_____ SEX □ F □ M SOCIAL SECURITY # _____ / _____ / _____

MARITAL STATUS: □ SINGLE □ DIVORCED □ LEGALLY SEPARATED □ PARTNER
□ MARRIED (SPOUSE NAME _____) □ WIDOWED □ UNKNOWN

RACE: _____ ETHNICITY: □ HISPANIC □ NON-HISPANIC

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

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

Who is your family care doctor? _____

We would like to send you a patient satisfaction survey after your visit; would you please share your preferred email address?

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
WORK □ YES □ NO

PATIENT EDUCATIONAL NEEDS: How do you learn best? Please Circle or explain in the area labeled "Other" how we can best serve you. (Circle one): Hearing information or reading information?

Other: Please List. _____

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: □ YES □ NO Authorized to release medical information to:

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 electronic 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

EMPLOYER NAME _____ ADDRESS _____

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

NAME _____ RELATIONSHIP TO PATIENT_____

PHONE (_____) _____ - _____

NAME _____ RELATIONSHIP TO PATIENT_____

PHONE (_____) _____ - _____

NAME _____ RELATIONSHIP TO PATIENT_____

PHONE (_____) _____ - _____

PHARMACY (RETAIL):

NAME _____

ADDRESS / LOCATION _____

PHONE (_____) _____ - _____

FAX (_____) _____ - _____

PHARMACY (MAIL ORDER):

NAME _____

ADDRESS / LOCATION _____

PHONE (_____) _____ - _____

FAX (_____) _____ - _____

MAIL ORDER UNIQUE MEMBER ID # _____

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

PLEASE LIST ANY IMMEDIATE FAMILY MEMBERS WHO ARE PATIENTS: (You may list more than one family member)

NAME: _____ RELATION: _____

ADDRESS: _____ PHONE: _____

Consent to medical treatment: 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.

Conditions of clinical and financial services: Your insurance will be automatically filed as a courtesy to you. Please be sure to provide a copy of your insurance card to staff. Insurance co-pays and unmet deductibles are due at time of service. I understand and acknowledge that I am liable for all charges designated my responsibility that is not paid by insurance.

***Authorization to release information*:** I hereby authorize my provider to release all information pertaining to my treatment to my insurance company or companies and to any other physician or health care provider to whom I may be referred. I hereby authorize regulatory and accrediting agencies to review my medical record during surveys or inspections.

Assignment of benefits: I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicaid, private insurance, and other health plans to: Catawba Valley Medical Group.

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 SIGNATURE) (DATE)

(RESPONSIBLE PARTY SIGNATURE) (RELATIONSHIP) (DATE)

CATAWBA VALLEY MEDICAL GROUP - PATIENT FINANCIAL POLICY – SPECIALTY CARE

Thank you for choosing Catawba Valley Medical Group as your health care provider. We appreciate the trust you place in us for your care.

Insurance When you arrive at our office for services, we ask you to complete forms to gather information about you and your insurance. Catawba Valley Medical Group will file all insurance provided to us as a courtesy service for our patients. Insurance co-pays and unmet deductibles are due at time of service. Please make sure you understand your insurance plan benefits and verify that we are in your plan's network so you are not inconvenienced by a reduced payment or denial. Payment of your bill is ultimately your responsibility.

Payment Payment is due at time of service. We accept cash, check, Visa, MasterCard, Discover and American Express. We also provide an additional payment option for patients whose needs require extended terms to pay balances in full. The AccessOne Med Card allows you to make monthly payments at a minimal interest rate. Please contact our Central Billing Office at 828.464.2210 to obtain more information about any of our payment options. We stand ready to assist you.

Non-Payment Please be aware that visits to Catawba Valley Urgent Care Saturday Clinic will include an additional convenience charge for after hours service. We expect that patients make efforts to render payment. Unfortunately, it may become necessary to make a decision concerning continued availability of services due to no payment efforts. Outstanding patient balances greater than $500 without payment may receive notice of dismissal, in which case no further services will be provided by Catawba Valley Medical Group. Unpaid balances may be referred to an outside agency for collection. Nonpayment to Access One Med Card will result in dismissal regardless of balance.

CATAWBA VALLEY MEDICAL GROUP - PATIENT EDUCATION

If you have a medical emergency, while receiving care, treatment or services in this location, life-saving actions will be started, even if you have an advanced directive.

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 rolling12 month period, you may be dismissed from the practices of Catawba Valley Medical Group and asked to seek care elsewhere.

How can patients be involved in their care? Speak Up:

S – Speak up if you have questions or concerns. If you still do not understand, ask again. It is your body and you have a right to know.
P – Pay attention to the care you get. Always make sure you are getting the right treatments and medicine by the right health care professionals. Do not assume anything.
E – Educate yourself about your illness. Learn about the medical tests you get, and your treatment plan.
A – Ask a trusted family member or friend to be your advocate (advisor or supporter).
K – Know what medicines you take and why you take them. Medicine errors are the most common health care mistakes.
U – Use a hospital, clinic, surgery center, or other type of health care organization that has been carefully reviewed by an outside party.
P – Participate in all decisions about your treatment. You are the center of the health care team.

After Hours Care Please call 911 or go to Catawba Valley Medical Center Emergency Department.

For additional educational resources to assist with self-management visit: www.cvmgonline.org.

I have read the Financial Policy and Patient Education, I understand, and agree to its terms.

X _____ Date _____
Signature of Patient or Responsible Party

☐ Catawba Valley Cardiology
p: 828.326.2354
f: 828.326.2385

☐ Catawba Valley Vascular Surgery
p: 828.322.9105
f: 828.328.4999

☐ Catawba Valley Pulmonology
p: 828.326.2660
f: 828.326.2671

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: _____
- ☐ 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, &/OR PSYCHIATRIC TREATMENT RECORDS
- ☐ 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

The information contained in this document is privileged and confidential. If the reader of this message is not the intended recipient, you are hereby notified that any distribution or copying of this communication is strictly prohibited. If you receive this communication in error, please notify us immediately. Thank you.