PATIENT INFORMATION	**ACCOUNT #:**			**Date:**
Patient Name:		Name of Referring Doctor / Phone Number:		
Address:		Primary Doctor:		
City/State/Zip:		Employer/School:		
Home Phone: Cell Phone: Work Phone:		Email Address:		
SSN:	Date of Birth:	Age:	Marital Status:	Sex:
Emergency Contact:	Relationship:		(H) Phone #: (C)	
Responsible Party:	Relationship:		DOB:	SSN:
Responsible Party Address:		City/State/Zip:		Phone #:
INSURANCE INFORMATION				
Primary Insurance:	Employer:	Secondary Insurance:		Employer:
Insurance ID #:	Insurance Group #:	Insurance ID #:		Insurance Group #:
Insured Name:		Insured Name:		
Address:		Address:		
City/State/Zip:		City/State/Zip:		
Insured DOB:	Insured SSN:	Insured DOB:		Insured SSN:

Financial Responsibility and Assignment of Insurance Benefits:

I guarantee payment to GFHS and affiliates (BCHCC, GFMC, SFM, SCC, HHHCtr, CHC, HHCtr, GCHD) of all charges for services provided to the patient. I understand I am personally responsible for all charges not covered by insurance. I authorize payment of surgical and medical benefits, which would otherwise be payable to me, to GFHS, Inc/GCHD for services rendered. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment under Title's V, XVIII and/or XIX of the Social Security Act is correct.

Consent for Healthcare and Release of Medical Information:

I voluntarily consent to healthcare treatment ('Treatment') from the physicians and staff at this GFHS, Inc/GCHD facility. **I consent to any necessary lab work, including HIV testing.** I am aware that the practice of medicine is not an exact science. No guarantees have been made to me regarding the result of treatments or examinations by my caregivers. I consent to the use and disclosure of protected health information about me for treatment, payment and healthcare operations. I have read this form. I have had the opportunity to ask questions and my questions have been answered.

Would you like information on advance directives?(Living Will, Health Care Power of Attorney, etc)
□ ***Yes*** □ ***No***

Signature of Patient or Authorized Person: _____ ***Date/Time*** _____
Insured Party or Financial Guarantor (if different from above): _____ ***Date/Time*** _____

Acknowledgement of Receipt of Joint Notice of Privacy Practices: I have received a copy of the GFHS Joint Notice of Privacy Practices. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice on GFHS's website at www.gfhs.info, by writing to the GFHS Privacy Officer, 991 W. Hudson Boulevard, Gastonia, NC 28052, or by requesting one at any GFHS provider location.

Signature of Patient or Authorized Person: _____ ***Date/Time:*** _____

Footnote: Gaston Family Health Services Incorporated, located in Gastonia, North Carolina, includes ***GFHS- Hudson, Bessemer City Health Care Center, Gaston Family Medical Center, Statesville Family*** Medicine, Helping Hands Health Center, Cherryville Health Center, Highland Health Center, Statesville Children's Clinic, Davidson Medical Ministries - Lexington, Davidson Medical Ministries - Thomasville; Affiliate: Gaston County Health Department.

For Staff Use Only

- ❑ Patient refused to sign after he / she received Joint Notice of Privacy Practices and was informed that signing the form merely acknowledges that the patient actually received the notice.
- ❑ Patient was initially treated for an emergency. Patient was either given the notice after stabilization or will be given the notice after transfer. (Circle One)
- ❑ We were unable to obtain a written acknowledgment of receipt of the Notice of Privacy Practice because:
  - An emergency existed and a signature was not possible at the time.
  - The individual refused to sign.
  - A copy was mailed with a request for a signature by return mail
  - Unable to communicate with the patient for the following reason:

_____

  - Other: _____

_____

_____ _____

Signature of Staff Date/Time

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

□ Interpreter accepted _____ □ Interpreter Refused

Name/Number of Person/Services Chosen/Used)

Gaston Family Health Services, Inc
Permission to Communicate

It is the policy of Gaston Family Health Services not to release Protected Health information, 'PHI', without consent and approval. Whenever returning telephone calls, or verifying appointments, we will not leave a message on the answering machine if the name or telephone number is not on the machine. Information regarding an appointment will not be given to anyone unless listed by you on this list. You may change this information at anytime.

I authorize GFHS to leave dental information as noted below:

			Name/Number
Home Telephone/Answering Machine	YES	NO	_____
Work Telephone-voicemail	YES	NO	_____
Cell Phone-voicemail	YES	NO	_____
Spouse (provide name)	YES	NO	_____
Parent (provide name)	YES	NO	_____
Other (provide name)	YES	NO	_____

Information to be released: Appointment information, Billing Information, and any information to any dentist that I have been referred to, that will also be involved in my care and treatment.

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a results of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____

Signature of Patient or Personal Representative Date

Signature of Patient or Personal Representative **Date**

Description of Personal Representative's Authority (attach necessary documentation)

GFHS Witness: _____ Date _____