Gaston Family Health Services

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:	Race:
Preferred method of communication: □ Phone □ Email □ Postal Mail					
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 its affiliates for 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 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 (i.e., physical and/or behavioral treatment) from the physicians, behavioral health providers, and staff of GFHS, Inc. I consent to any necessary lab work, including HIV testing. I am aware that neither the practice of medicine nor the delivery of mental/behavioral health treatment are an exact science. No guarantees have been made to me regarding the results of treatments or examinations by my caregivers. I understand that GFHS employs a "team based" approach to the delivery of healthcare and that health information may be exchanged between GFHS providers and staff members involved in my care to ensure appropriate treatment planning and adequate care. I consent to the use and disclosure of protected health information about me for treatment, payment and healthcare operations. I certify that I have read and understand this form.

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 as follows:

- GFHS's website: http://www.gfhs.info
- By writing to the GFHS Privacy Officer, 200 E. Second Avenue, 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

_____ _____

Witness Signature Date / Time

- ❑ 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: (Choose One)
  - Given the notice after stabilization ***Or***
  - Will be given the notice after transfer
- ❑ 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: _____

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

□ Interpreter accepted _____ □ Interpreter Refused

Name / Number of Person/Services Chosen/Used