Gaston Family Health Services

ADULT- Consent For Evaluation of Treatment and Right to Refuse Treatment

PATIENT DEMOGRAPHICS

***DATE OF COMPLETION** (mm/dd/yyyy):* ______________________

Legal Name (Last, First, MI):	**Preferred Name:**	**Primary Doctor:**

Date of Birth (mm/dd/yyyy): _____ /______ /_______	***Birth Sex***: ☐ Female ☐ Male ☐ Other ☐ Undefined
Age: _________________	***Gender Identity***: ☐ Female ☐ Transgender Female to Male ☐Male ☐Transgender Male to Female ☐ GenderQueer ☐Other ☐Chose not to disclose
SSN: ______-_____-_______	***Race:*** ☐ Black / African American ☐ More than one race ☐ White ☐ Asian ☐ American Indian /Alaska Native ☐Native Hawaiian ☐ Other Pacific Islander ☐ Unreported /Refuse to report race
Marital Status: ☐ Single *Are you in a relationship with anyone*: _________________ ☐ Married ☐ Divorced ☐ Separated ☐ Widow / Widower	

Home Address:	***City***	***NC***	***Zip code***

Home Phone:	***Cell Phone:***	***Work Phone:***	***Email Address:***

Preferred method of communication: ☐ Phone ☐ Email ☐ Postal Mail

Emergency Contact 1:	***Relationship:***	***Home Phone:***	***Cell Phone:***
Emergency Contact 2:	***Relationship:***	***Home Phone:***	***Cell Phone:***
Responsible Party:	***Relationship:***	***Date of Birth*** (mm/dd/yyyy): _____ /______ /_______	**SSN**: ______-_____-______

Responsible Party Home Address:	***City***	***NC***	***Zip code***

Employer / School:

INSURANCE INFORMATION

Primary Insured's Name: ______________________________	***Secondary Insured's Name:*** ______________________________
Date of Birth (mm/dd/yyyy) | ***SSN:*** ______-_____-_______ _____ /______ /_______	***Date of Birth*** (mm/dd/yyyy) | **SSN**: ______-_____-_______ _____ /______ /_______

Primary Insurance:	***Employer:***	***Secondary Insurance:***	***Employer:***
Insurance ID Number:	***Group Number:***	***Insurance ID Number:***	***Group Number:***

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Primary Insurance Address:	***City***	***NC***	***Zip code***
Secondary Insurance Address:	***City***	***NC***	***Zip code***

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS:

Consent for Healthcare and Release of Medical Information:

I voluntarily consent to healthcare treatment (i.e., Medical Care and/or Behavioral Health) from the Medical and Behavioral Health providers, and staff of GFHS, Inc. and all its affiliates. I consent to all necessary treatment of illness and injuries and preventative care including screenings, lab work (including HIV testing and STD testing), immunizations and referrals. 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 (PHI) about me for treatment, payment and healthcare operations. 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. I certify that I have read and understand this form.

This consent is renewable annually. I may withdraw authorization for services at any time.

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*** _________

Footnote: Gaston Family Health Services Incorporated, located in Gastonia, North Carolina, includes: GFHS- Hudson, GFHS Peds and Teen Wellness, 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, Catawba Family Care, Davidson Medical Ministries - Lexington, Davidson Medical Ministries - Thomasville; ***Dental Affiliates***: Catawba Family Dentistry, Davidson Health Services General Dentistry, GFHS General Dentistry, GFHS Pediatric Dentistry, Statesville Family Dentistry; ***Affiliate***: Local Health Departments: Catawba, Davidson, Gaston, Iredell, Lincoln, Mecklenburg.

FOR STAFF USE ONLY:

____ _________________________________

Witness Signature Date / Time

☐ Patient refused to sign

☐ 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

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

☐ Interpreter accepted ____ ☐ Interpreter Refused

Name / Number of Person/Services Chosen/Used

Consent to Treat- Revised April 2017