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

SSN:______-_____-______

Race:
- ☐ Black / African American
- ☐ White
- ☐ American Indian /Alaska Native
- ☐ Asian
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ More than one race
- ☐ Unreported /Refuse to report race

Ethnicity:
☐ Hispanic ☐ Non- Hispanic

Sexual Orientation –
- ☐ Straight or Heterosexual
- ☐ Lesbian, gay or homosexual
- ☐ Bisexual
- ☐ Something else
- ☐ Don't know
- ☐ Choose not to answer

Marital Status:
☐ Single ☐ Married ☐ Divorced
☐ Separated ☐ Widow / Widower

***Gender Identity**: (Check one):*
- ☐ Male ☐ Female
- ☐ Transgender Male/ Trans Man/ Female-to-Male (FTM)
- ☐ Transgender Female/ Trans Woman/ Male-to-Female
- ☐ GenderQueer (neither exclusively male nor female)
- ☐ Additional gender category/ Other. Please specify: ____________
- ☐ Chose not to answer

Disabled: ☐ Yes ☐ No Homeless: ☐ Yes ☐ No Veteran: ☐ Yes ☐ No

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

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

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

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:

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

"Caring For Our Community"

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:		
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 Personal Health Information:

I voluntarily consent to healthcare treatment (i.e., Dental, Medical Care and/or Behavioral Health) from the 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), 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.

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, Gaston Complete Health, 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.

Signature of Patient or Authorized Person:____________________***Date/Time***__________

Insured Party or Financial Guarantor (if different from above):________________***Date/Time***________

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:

☐ LEP: Interpreter accepted____________________ ☐ LEP: Interpreter Refused: ____________

Name / Number of Person/Services Chosen/Used

Rev: Feb2017;April2017;Oct2017

Permission to Communicate - Authorization for Release of Information

Name of Patient ______________________________ Date of Birth (MM/DD/YYYY) ____________

______________________________ is authorized to release protected health information about the above named patient in the following manner and to identified persons.
Facility Name

So that Gaston Family Health Services may serve you better, you have the option of providing us with a list of caregivers with whom we may discuss your appointments, referrals, test, lab results and any other health information you desire us to share.

Describe how information will be received. Check each person/entity that you approve to receive information.	**Describe the information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail ☐ Mail	☐ Medical (Appointments, referrals, test and lab results and any other health information) ☐ Financial ☐ Other ____________
☐ Other person(s): Name / Phone Number / Relationship ______________________ ______________________ ______________________	☐ Medical (Appointments, referrals, test and lab results and any other health information) ☐ Financial ☐ Other ____________
☐ Email communication-Provide email address* ______________________ *For email communication to occur, please accept the disclosure below:	☐ Medical (Appointments, referrals, test and lab results and any other health information) ☐ Financial ☐ Breach notification
☐ Text communication – Provide number * ______________________ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: ____________

☐ ***For email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.

☐ Photo of patient received by patient or legal guardian	☐ May be posted in office
☐ Photo taken by staff (Example: pre/post procedure)	☐ May be posted on website
☐ Other	☐ Other ____________

Please sign on the back

Revised Oct 2014; April 2017

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

____ Date _______________

Signature of Patient or Personal Representative

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

____

☐ I am revoking my authorization to disclose the previously requested protected health information.

____ Date _______________

Signature of Patient or Personal Representative

Please take time to fill out this form.
Thank you for trusting us with your care.

Date Completed__________
Name__________ Date of Birth__________
Form Completed by □Self □Other:__________
Preferred Pharmacy__________
Reason for Visit__________
Email address__________
Preferred method of communication:
□ Email □ Phone □ Mail

PATIENT MEDICAL HISTORY

- □ Blood Disease
- □ Breast Disease
- □ Cancer
- □ Diabetes/Thyroid Problems
- □ Female Problems
- □ Head, Eyes, Ear, Nose, Throat
- □ Heart Disease
- □ High Blood Pressure
- □ HIV
- □ Kidney Problems
- □ Lung Problems (COPD, Asthma)
- □ Male Problems
- □ Mental Illness
- □ Osteoporosis
- □ Rheumatology/Arthritis
- □ Skin Problems
- □ Stroke/Seizures
- □ Stomach Problems
- □ STI/STD
- □ Other

LAST SPECIALTY VISIT/HOSPITALIZATION/SURGERY

Reason Date

____

____

□ None

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children	Don't Know
Bleeding Problems	□	□	□	□	□	□	□
Cancer	□	□	□	□	□	□	□
Diabetes/Thyroid Problems	□	□	□	□	□	□	□
Glaucoma	□	□	□	□	□	□	□
High Blood Pressure	□	□	□	□	□	□	□
Kidney Problems	□	□	□	□	□	□	□
Mental Illness /Depression	□	□	□	□	□	□	□
Osteoporosis	□	□	□	□	□	□	□
Stroke/Seizures	□	□	□	□	□	□	□
Substance Abuse	□	□	□	□	□	□	□

PREGNANCY HISTORY

Currently Pregnant □ Yes □No □Not Applicable

Past Pregnancies #______ Dates (Month/Year)__________ Abortions/Miscarriages # ________

MEDICATION

List any prescription and non-prescription medication you take regularly (include OTC, herbals, vitamins, etc.)

____

____

____

____

____

ALLERGIES

Allergies | Reaction

____

____

□ No Known Allergies

IMMUNIZATION (SHOT) HISTORY

	Date (Mo/ Yr)	Where
□ Flu		
□ Pneumonia		
□ Tetanus		
□ Hep A		
□ Hep B		

WELL CARE

	Date (Mo/Yr)	Results		Where
Last Menstrual Cycle				
Last PAP test		□ Normal	□ Abnormal	
Last Mammogram		□ Normal	□ Abnormal	
Colonoscopy		□ Normal	□ Abnormal	
Prostate Cancer Screening		□ Normal	□ Abnormal	
TB Screening		□ Normal	□ Abnormal	
HIV Screening		□ Normal	□ Abnormal	
Hep C Screening		□ Normal	□ Abnormal	

HEALTH HABITS

□ Tobacco	□ Cigarettes ____ packs/day □ Interest in stopping	□ Cigars/Pipes □ No interest in stopping	□ Chew/Dip
□ Alcohol	Amount ______ ________/day		
□ Physical Activity	Minutes_____/day	# Days____/week	
□ Caffeine	Cups_____/day		
□ Sexual Activity	□ Inactive	□ One Partner	□ More than one partner
□ Seatbelt use	□ Always	□ Sometimes	□ Never
Are you satisfied with your eating habits?		□ yes	□ no

SOCIAL CONSIDERATIONS

Are there any religious/ cultural consideration regarding your care? □ yes □ no

If yes, please explain ____

Are you having any experiences at home that make you feel unsafe? □ yes □ no

If yes, please explain ____

Preferred Language ____

LEARNING NEEDS ASSESSMENT

Do you have any of the following?

Learning disabilities	□ yes	□ no
Visual limitations	□ yes	□ no
Hearing limitations	□ yes	□ no

If yes, please explain ____

Required Accomodations____