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): _____ /_____ /_____

Age: _____

SSN: _____-_____-_____

Marital Status:
☐ Single
Are you in a relationship with anyone: _____
☐ Married
☐ Divorced ☐ Separated
☐ Widow / Widower

Birth Sex: ☐ Female ☐ Male ☐ Other ☐ Undefined

Gender Identity: ☐ Female ☐ Transgender Female to Male ☐Male ☐Transgender Male to Female ☐ GenderQueer ☐Other ☐Chose not to disclose

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

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

Gaston Family Health Services

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

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 understand that I am enrolled in the Health Information Exchange, but at any time can opt-out by completing an Opt-Out Form provided by my provider. 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

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 ☐ Photo taken by staff (Example: pre/post procedure) ☐ Other	☐ May be posted in office ☐ May be posted on website ☐ Other_____

Please sign on the back

Revised Oct 2014; April 2017

Permission to Communicate - Authorization for Release of Information

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.
- I understand I am automatically enrolled in the Health Information Exchanges, but at any time can opt-out by completing an Opt-Out form provided by my provider.

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