GRANVILLE VANCE public health

Registration Form

Today's Date: _____ Appt Time: _____Arrived: ____Clinic: _____ (New or Established)

Patient's Last Name	First Name	Middle Initial	DOB	SSN
Gender	Marital Status	Ethnicity	Language	Race
Address	City	State/ Zip	Home Phone	Cell Phone
County Location		Emergency Contact		E-mail

Insurance Plan (private, M'caid,M'care)	Insurance Address	Insured Party	Insured Address	Policy Number
Pharmacy	Pharmacy Telephone #			

Person Responsible for the bill:	Birth Date:	Address	Phone Number
Occupation	Employer	Employer Address	Employer Phone Number
Family Head	Household Size	Income	Program
Income Source	Amount/Period	Verification/Date	Employer
Self Pay%	If income is "0"-How do you support yourself?		

Primary Care Provider	Primary Care Telephone #	Emergency Contact	Emergency Contact Telephone#	

The above information I have given is correct. I understand Granville Vance HD has the right to verify this information.

Signature: _____ Date: _____

If no signature can be obtained: Verbal authorization for treatment and affirmation of agreement of the General Consent, Terms and Conditions, Privacy Practices (copies given to patient) witnessed by: _____

Date: _____

Additional Comments:

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General Consent Form

I hereby voluntarily consent to medical and/or dental examinations, treatments and procedures which are deemed necessary in the opinion of my physician and health care providers, including HIV tests, laboratory tests and x-rays. I understand that my medical information is strictly confidential and is protected by North Carolina General Statute 130A-143 and no guarantees or warranties have been made to me concerning the results of the examinations, treatments or procedures. My signature acknowledges that I have been given the opportunity to ask questions about this consent form and the opportunity to refuse services.

NOTICE OF PRIVACY PRACTICES

Your Rights - When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can contact the Health Department Privacy Officer, Wendy Smith at (252) 492-7151 or wsmith@gvdhd.org • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again
In these cases, we never share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Changes to the Terms of this Notice - We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Our Uses and Disclosures - How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you. ***Example: A doctor treating you for an injury asks another doctor about your overall health condition.***
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary. ***Example: We use health information about you to manage your treatment and services.***
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities. ***Example: We give information about you to your health insurance plan so it will pay for your services.***

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

1. **Help with public health and safety issues - We can share health information about you for certain situations such as:**
   - Preventing disease
   - Helping with product recalls
   - Reporting adverse reactions to medications
   - Reporting suspected abuse, neglect, or domestic violence
   - Preventing or reducing a serious threat to anyone's health or safety
2. **Do research -** We can use or share your information for health research**.**
3. **Comply with the law -** We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law**.**
4. **Respond to organ and tissue donation requests -** We can share health information about you with organ procurement organizations**.**
5. **Work with a medical examiner or funeral director -** We can share health information with a coroner, medical examiner, or funeral director when an individual dies**.**
6. **Address workers' compensation, law enforcement, and other government requests -** We can use or share health information about you:
   - For workers' compensation claims
   - For law enforcement purposes or with a law enforcement official
   - With health oversight agencies for activities authorized by law
   - For special government functions such as military, national security, and presidential protective services
7. **Respond to lawsuits and legal actions -** We can share health information about you in response to a court or administrative order, or in response to a subpoena**.**
8. **Health Information Exchange (HIE) -** We may provide your health care information to the NC Health Information Exchange Authority (HIEA). The HIE is a health information database where other health care providers caring for you can access your medical information if they are members of the HIEA. Accessing your information can help your healthcare provider provide you with well-informed care quickly because s/he will have learned about your medical history from the HIEA. If you do not want your medical information to be contributed to the HIEA and shared with member healthcare providers, you can opt out by asking us for an opt-out form or by visiting https://hiea.nc.gov/patients/your-choices to download and complete the opt-out form. Note that if you opt out, your providers may not have the most recent information about you which may affect your care. If you choose to opt out, there are measures you can take at this link to opt in at a later date https://hiea.nc.gov/patients/your-choices. If you are under the age of 18, please note the NC HIEA will not process your opt-out unless your parent or legal guardian has signed your opt-out form, or you have been emancipated. If you are a minor and you receive treatment for (1) venereal disease and other reportable diseases, (2) pregnancy, (3) abuse of controlled substances or alcohol, and (4) emotional disturbance, please speak with your health care provider to see if you are able to request that this information not be disclosed to the NC HIEA.

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TERMS AND CONDITIONS FOR PATIENT

Upon penalties prescribed by law, I hereby affirm to the best of my knowledge and belief, my income statement is true and correct. I understand that a state reviewer may check the information, and I agree to provide the financial records required to carry out this review. I understand I have three days from the date of service to provide financial records. I also understand that my employer may be asked to verify information concerning my income.

I understand and agree, if uninsured, I will be charged according to my household income and the charges will be adjusted per the sliding fee scale at _____ percent.

I request the payment of authorized Medicaid / Medicare / 3rd Party Payor benefits be made on my behalf to the Granville Vance District Health Department for any services provided. I authorize any holder of medical information (to include HIV information / Substance Use / Mental Health and Social Data) about me to release to the Health Care Financing Administration (HCFA) and its agents any information needed to determine these benefits payable for related services.

I understand that my signature will serve as legal "signature on file" for purposes of filing my insurance claims and payment of benefits to the GVDHD for services rendered.

I understand that my insurance company will send and Explanation of Benefits (EOB) to the address provided on the HCFA form when any claims are processed for services provided.

I understand that the GVDHD will forward my Medicaid/Medicare/3rd Party Payor information to private laboratories contracted with the GVDHD for processing of outsourced laboratory testing. The private laboratory will bill directly for these services.

Medicaid payments are considered payment in full for services rendered.

I agree that I am responsible for any remaining balance due to the Health Department after insurance payments, if any, have been applied; including payment for denied claims, deductible amounts, and/or co-insurance.

I agree to repay the GVDHD any money I receive from insurance for services that the GVDHD provided for me. I further agree that failure to repay assigned insurance benefits to the GVDHD may be reason for denial or restriction of future services until such amounts have been repaid.

I confirm that «Patient Email» email address is correct belongs to me as the patient if over age 13 or the parent of above named patient who is age 10 or under. Further, I authorize Granville Vance Public Health to create an online portal account which will contain my health information and acknowledge that they will create a username which will be provided to me via this email address so that I may create my own password. I am aware that I should not provide my username and password to anyone including GVPH staff members.