CAPE FEAR VALLEY HEALTH

Bariatric Weight Loss Program

PATIENT INFORMATION:

Name Last _____ First _____ Middle _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Social Security # _____ Email _____

Employer _____ Occupation _____

Employer's Address _____

Home Phone # _____ Work Phone # _____ Other _____

Race: ☐ White ☐ Black ☐ Other **Sex:** ☐ M ☐ F **Language:** ☐ English ☐ Spanish ☐ Other _

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ Other

RESPONSIBLE PARTY INFORMATION: (If Not Above)

Name Last _____ First _____ Middle _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Social Security # _____

Employer _____ Occupation _____

Employer's Address _____

Home Phone # _____ Work Phone # _____ Other _____

Race: ☐ White ☐ Black ☐ Other **Sex:** ☐ M ☐ F **Language:** ☐ English ☐ Spanish ☐ Other _

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ Other

Patient's Relationship to Responsible Party: ***(Please check appropriate box)***

☐ Self-18 ☐ Spouse-01 ☐ Mother-32 ☐ Father-33 ☐ Child-19 ☐ Adopted Child-09 ☐ Foster Child-10 ☐ Dependent-23

☐ Stepson/Stepdaughter-17 ☐ Handicapped Dependent-22 ☐ Emancipated Minor-36 ☐ Dependent of Minor Dependent-24

☐ Niece/Nephew-07 ☐ Grandparent-04 ☐ Grandson/Granddaughter-05 ☐ Ward-15 ☐ Significant Other-29 ☐ Life Partner-53

☐ Other Adult-34 ☐ Employee-20 ☐ Injured Plaintiff-41 ☐ Other-G8 ☐ Child where insured has no financial responsibility-43

Is This Visit Related To:

☐ Individual Were you injured on the job? ☐ Yes ☐ No Date of Injury _____ Industrial Claim # _____

☐ Accident Was an automobile involved? ☐ Yes ☐ No Date of Injury _____ Attorney Name _____

☐ Other Date of Accident _____ Attorney Name _____

IN CASE OF EMERGENCY CONTACT:

Name _____ Relationship To Patient _

Address _____ Phone # _____

Nearest Relative Not Living In Household _____ Phone # _____

(PLEASE COMPLETE THE INSURANCE INFORMATION ON THE BACKSIDE OF THIS FORM BEFORE SIGNING)

I, _____, certify that the completed information is correct and I received the Notice of Privacy Practice Form on _____ /_____ / _____.

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INSURANCE INFORMATION:

Primary Insurance Company: _____ Policy #_____ Group #_____

Subscriber's Name _____ Subscriber's Date of Birth _____

Subscriber's Address _____ City _____ State _____ Zip _____

Subscriber's Social Security # _____ Subscriber's Sex ☐ Male ☐ Female

Subscriber's Relationship to Responsible Party ☐ Self-1 ☐ Spouse-2 ☐ Other-0

Secondary Insurance Company: _____ Policy #_____ Group #_____

Subscriber's Name _____ Subscriber's Date of Birth _____

Subscriber's Address _____ City _____ State _____ Zip _____

Subscriber's Social Security # _____ Subscriber's Sex ☐ Male ☐ Female

Subscriber's Relationship to Responsible Party ☐ Self-1 ☐ Spouse-2 ☐ Other-0

Tertiary (3rd) Insurance Company: _____ Policy #_____ Group #_____

Subscriber's Name _____ Subscriber's Date of Birth _____

Subscriber's Address _____ City _____ State _____ Zip _____

Subscriber's Social Security # _____ Subscriber's Sex ☐ Male ☐ Female

Subscriber's Relationship to Responsible Party ☐ Self-1 ☐ Spouse-2 ☐ Other-0

I, _____, certify that the completed information is correct and I received the Notice of Privacy Practice Form on _____ /_____ / _____.

CAPE FEAR VALLEY HEALTH

Bariatric Weight Loss Program

PHYSICIAN OFFICE PRACTICES

GENERAL CONSENT FOR TREATMENT

I authorize the physicians of Cumberland County Hospital System Inc, d/b/a Cape Fear Valley Health system (CFVHS), or authorize agents and employees of CFVHS, to administer medical treatment or diagnostic procedures and do any acts which they deem in their judgment necessary or proper for treatment. I consent to additional and different treatment or procedures as may be necessary. I acknowledge that no guarantee has been made to me concerning the results of any such treatment or procedures. I agree to receive communication on the phone number(s) provided regarding appointment reminders, appointment instructions, medical results, etc. This consent shall be effective from the date it is executed until the date I terminate it by communication my revocation to my physician. By signing below, I am indicating that I am fully informed as to the contents of this consent and I have read it and it has been explained to me.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize CFVHS to release all information necessary to secure the payment of benefits for medical services. I authorize this signature on all insurance submissions whether manual of electronic. I specifically authorize the physicians of CFVHS to disclose information in my medical records, including copies to:

- Government agencies or programs;
- Managed care organizations and/or insurance companies;
- Utilization review organization contracted by my employer, insurance company or government agency or program;
- Physicians or health care institutions responsible for further care or follow up treatment to serve the goal of continuation of my care.

THIS AUTHORIZATION INCLUDES THE RELEASE OF MEDICAL RECORDS AND/OR INFORMATION CONCERNING DRUG ABUSE RELATED CONDITIONS, ALCOHOLISM, PSYCHOLOGICAL CONDITIONS, PSYCHIATRIC CONDITIONS, AND/OR COMMUNICABLE DISEASES INCLUDING ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS), OR TESTS FOR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV), IF PRESENT.

I understand this authorization may be revoked by me at any time except to the extent action has been taken prior to revocation.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment directly to CFVHS of all benefits, if any, otherwise payable to me including major medical insurance for services rendered.

FINANCIAL AGREEMENT

The undersigned agree jointly and severally, whether they sign as guarantor or as patient, that in consideration of the services rendered to the patient, they do hereby guarantee payments to CFVHS. I (We) acknowledge that payment is at the time of treatment unless other arrangements are made. I (We) accept full financial responsibility for all charges not covered by insurance. I understand that I am financially responsible for all charges regardless of insurance payment.

Patient/Legal Representative Signature _____ Date _____ Time _____

Print Name _____ Relationship to Patient _____

Witness Signature _____ Date _____ Time _____

Print Name _____ Relationship to Patient _____

Translator/Interpreter Signature _____ Date _____ Time _____

*Translation Service Utilized Session ID# _____

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PHYSICIAN OFFICE PRACTICES

Patient Questionnaire

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis:

   Name: _____ Relationship: _____

   Name: _____ Relationship: _____

2. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

   Name: _____ Relationship: _____ Phone Number: _____

   Name: _____ Relationship: _____ Phone Number: _____

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home:

   _____

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL" ☐ Yes ☐ No

5. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home phone number: _____ **"I am fully aware that a cell phone is not a secure and private line."**

6. Can confidential messages (i.e. appointment reminders) be left on your telephone answering machine or voicemail? ☐ Yes ☐ No **(If no, you will not receive an appointment reminder.)**

7. Would you like to participate in MYCHART? ☐ Yes ☐ No

   Using MyChart, you can:

   - Communicate with your care team
   - View your recent clinic visits
   - Access your test results
   - Request Prescription Renewals
   - And more...

   To join please provide your email where your activation code will be sent: _____

8. I have been given a copy of my Patient Rights and Responsibilities. ☐ Yes ☐ No

9. I have been given a copy of the Joint Notice of Privacy Practices. ☐ Yes ☐ No

10. Advance Directives: Please check appropriate box

    Health Care Power of Attorney ☐ Yes ☐ No

    Living Will ☐ Yes ☐ No

    Have you supplied us with a copy ☐ Yes ☐ No

Patient/Legal Representative Signature: _____ Date: _____ Time: _____

Print Name: _____ Relationship to Patient: _____

Witness Signature: _____ Date: _____ Time: _____

Print Name: _____