

# NORTH CAROLINA SURGERY

## PATIENT IDENTIFICATION

Patient's Legal Name \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE)

**Rex Healthcare will compare your Legal Name to your name as it appears on your insurance card.**

Gender \_\_\_\_ Last 4 numbers Social Security# (some insurances require full SS) \_\_\_\_\_

Birth Date \_\_\_\_\_

**PATIENT INFORMATION:** Race \_\_\_\_\_ Hispanic \_\_\_\_\_ Non-Hispanic \_\_\_\_\_ Language \_\_\_\_\_

Mailing Address \_\_\_\_\_

Physical Address (if different from mailing address) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone # \_\_\_\_\_ Mobile Phone # \_\_\_\_\_ Email Address \_\_\_\_\_

Referring Physician \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Other Physicians to Whom You Want Communication Sent \_\_\_\_\_

## **PATIENT EMPLOYMENT INFORMATION**

Status: Full-time \_\_\_\_ Part-time \_\_\_\_ Retired \_\_\_\_ Retirement Date \_\_\_\_\_ Full Time Student? Y/N Other \_\_\_\_\_

Employer's Name \_\_\_\_\_ Phone # \_\_\_\_\_

## **GUARANTOR INFORMATION (Person Financially Responsible if different than patient)**

Name of Guarantor \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Last 4 Digits of Social Security # \_\_\_\_\_ Gender \_\_\_\_\_ Birth Date \_\_\_\_\_

Mailing Address \_\_\_\_\_

Physical Address (if different from mailing address) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone # \_\_\_\_\_ Employer's Name \_\_\_\_\_

## **EMERGENCY CONTACT INFORMATION**

Name of Emergency Contact \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Mailing Address \_\_\_\_\_

Physical Address (if different from mailing address) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

## **PRIMARY INSURANCE**

Name of Insurance Company \_\_\_\_\_

Policyholder's Name (if other than patient) \_\_\_\_\_ Relationship \_\_\_\_\_

Birth Date \_\_\_\_\_ Gender \_\_\_\_\_

## **SECONDARY INSURANCE**

Name of Insurance Company \_\_\_\_\_

Policyholder's Name (if other than patient) \_\_\_\_\_ Relationship \_\_\_\_\_

Birth Date \_\_\_\_\_ Gender \_\_\_\_\_

## **ACCIDENT INFORMATION** (Complete this section ONLY if your condition is accident related)

Type of Accident (Auto, Work, Other) \_\_\_\_\_ Description \_\_\_\_\_

Accident Date and Time \_\_\_\_\_ Place of Accident (City,County,State) \_\_\_\_\_

Patient/Authorized Representative Signature \_\_\_\_\_ Date \_\_\_\_\_

# NORTH CAROLINA SURGERY

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<b>NAME</b> _____	<b>DOB</b> _____
Decision Maker in the Event of Emergency _____	Phone# _____

**ALLERGIES:**

_____	_____
_____	_____
_____	_____
_____	_____

**MEDICATIONS:** Please list all prescriptions and over the counter medications, herbs and vitamins

Name	Dose	Name	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**PHARMACY:**

Name: \_\_\_\_\_ Address: \_\_\_\_\_

**MEDICAL HISTORY:**

Breast Cancer-----	<input type="checkbox"/>	Colon polyps-----	<input type="checkbox"/>	Pancreatitis-----	<input type="checkbox"/>
Gallstones-----	<input type="checkbox"/>	Diverticulitis-----	<input type="checkbox"/>	Rectal bleeding-----	<input type="checkbox"/>
Colon cancer-----	<input type="checkbox"/>	Fibrocystic breast---	<input type="checkbox"/>	Thyroid nodule-----	<input type="checkbox"/>
Abnormal EKG-----	<input type="checkbox"/>	Heart disease-----	<input type="checkbox"/>	Heart attack-----	<input type="checkbox"/>
Alcoholism-----	<input type="checkbox"/>	Diabetes-----	<input type="checkbox"/>	Seizures -----	<input type="checkbox"/>
Anemia-----	<input type="checkbox"/>	Hepatitis-----	<input type="checkbox"/>	Stroke-----	<input type="checkbox"/>
Asthma-----	<input type="checkbox"/>	HIV/AIDS-----	<input type="checkbox"/>		
CHF-----	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>		
Cirrhosis-----	<input type="checkbox"/>	Kidney disease-----	<input type="checkbox"/>		
Clotting disorder-----	<input type="checkbox"/>				
COPD-----	<input type="checkbox"/>				

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**SURGICAL HISTORY:**

Appendectomy-----	<input type="checkbox"/>	C-section-----	<input type="checkbox"/>	Prostate surgery-----	<input type="checkbox"/>
Brain surgery-----	<input type="checkbox"/>	Eye surgery-----	<input type="checkbox"/>	Small intest. Surgery	<input type="checkbox"/>
Breast surgery-----	<input type="checkbox"/>	Fracture repair-----	<input type="checkbox"/>	Spine surgery-----	<input type="checkbox"/>
Open heart surgery-----	<input type="checkbox"/>	Hernia surgery-----	<input type="checkbox"/>	Tubal ligation-----	<input type="checkbox"/>
Gallbladder surgery-----	<input type="checkbox"/>	Hysterectomy-----	<input type="checkbox"/>	Valve replacement---	<input type="checkbox"/>
Colon surgery-----	<input type="checkbox"/>	Joint replacement-----	<input type="checkbox"/>	Vasectomy-----	<input type="checkbox"/>
Cosmetic Surgery-----	<input type="checkbox"/>	Stent Placement-----	<input type="checkbox"/>		

**FAMILY HISTORY:**

Relationship	alive/deceased	birth defects	breast cancer	cancer	clotting disorder	COPD	Heart disease	Hypertension	kidney disease
Mother									
Father									
Sister									
Brother									
Daughter									
Son									

**SOCIAL HISTORY**

Tobacco Use No \_\_\_ Yes \_\_\_ former \_\_\_  
 Alcohol Use No \_\_\_ Yes \_\_\_ smoker  
 Drug Use No \_\_\_ Yes \_\_\_

**DOMESTIC ABUSE**

Is abuse, violence, or sexual assault a problem for you in any way? No \_\_\_ Yes \_\_\_  
 Does your partner/caregiver threaten you in anyway? No \_\_\_ Yes \_\_\_

INSTRUCTIONS: PLEASE CIRCLE "y" FOR ANY CURRENT SYMPTOMS

<u>CONSTITUTIONAL</u>		<u>RESPIRATORY</u>		<u>ENDOCRINE</u>		<u>NEUROLOGICAL</u>					
Y	N	Appetite change	Y	N	Chest tightness	Y	N	Cold intolerance	Y	N	Dizziness
Y	N	Chills	Y	N	Choking	Y	N	Heat intolerance	Y	N	Headaches
Y	N	Sweating	Y	N	cough	Y	N	Excessive thirst	Y	N	Light-headedness
Y	N	Fatigue	Y	N	Shortness of breath	<u>GU</u>		Y	N	Numbness	
Y	N	Fever	Y	N	Wheezing	Y	N	Painful urination	Y	N	Seizures
Y	N	Weight change	<u>CARDIOVASC.</u>		Y	N	Flank pain	Y	N	Fainting	
<u>MUSCULOSKEL.</u>		Y	N	Leg swelling	Y	N	frequency	Y	N	Tremors	
Y	N	Back pain	Y	N	Palpitations	Y	N	Blood in urine	Y	N	Weakness
Y	N	Gait problems	<u>GI</u>		Y	N	penile/vaginal discharge	<u>HEMATOLOGICAL</u>			
Y	N	joint swelling	Y	N	Distention	Y	N	scrotal/Pelvic pain	Y	N	Adenopathy
Y	N	neck pain	Y	N	Abdominal pain	Y	N	Urinary urgency	Y	N	Bruise/bleed easy
		Y	N	Anal bleeding	Y	N	Vaginal bleeding	<u>SKIN</u>			
		Y	N	Blood in stool	Y	N	Vaginal discharge	Y	N	Color changes	
		Y	N	Constipation			Y	N	Rash		
		Y	N	Diarrhea			Y	N	Wound		
		Y	N	Nausea							

Y N Vomiting

Patient Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_

**Limited Release of Information to Family/Friends for Physician Clinics  
HIM# 1315s**

**I give my permission to my physician practice that is part of the UNC Health Care System to share certain personal health information about me with the individuals listed below.** These individuals will only be given information about me that is related to their involvement in my care or payment for my care.<sup>1</sup> I understand that I am not required to complete this form in order to obtain health care.

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Relationship: \_\_\_\_\_ Talk to this person about (*check each box that applies*):

Any non-sensitive<sup>2</sup> information regarding my health care or payment for my health care.

**OR**

Only these things:

My appointments – scheduling & reminders	My test results
My after visit summary (AVS)	My bills
Other:	

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Relationship: \_\_\_\_\_ Talk to this person about (*check each box that applies*):

Any non-sensitive<sup>2</sup> information regarding my health care or payment for my health care.

**OR**

Only these things:

My appointments – scheduling & reminders	My test results
My after visit summary (AVS)	My bills
Other:	

**If I change my mind about the people or the contact information I have listed in this form, I will complete a new form with such changes.**

\_\_\_\_\_  
DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

PATIENT SIGNATURE (or Authorized Representative)

PRINTED NAME & RELATIONSHIP (if not patient): \_\_\_\_\_

<sup>1</sup> This form is not a substitute for a health care power of attorney or other formal designation of an individual authorized to make health care decisions for you if you are not able. If an individual listed above is your guardian or agent (under a power of attorney), or is otherwise authorized by law to act on your behalf, your health care provider may share as much of your personal health information with that person as the law permits.

**This form is not a substitute for a valid HIPAA compliant written authorization when it is required to release copies of medical and billing records or information.**

<sup>2</sup> Non-sensitive information excludes mental health, alcohol and substance abuse, HIV and other communicable diseases, and genetic testing. **This form is not considered sufficient authorization to release sensitive information.**



## GENERAL CONSENT FOR TREATMENT (PAGE 1 of 2) HIM #129s

I understand that the University of North Carolina Health Care System (UNC Health) is an integrated health system made up of various entities as reflected at [www.unchealthcare.org/documentapplicability](http://www.unchealthcare.org/documentapplicability) (each referred to in this form as a “UNC Health affiliate” or collectively as “UNC Health affiliates”). **This consent will be effective for 1 year after the date I sign it at any UNC Health affiliate of which I am a patient; however, this consent will not expire for services, claims processing or collection activities for admissions or visits occurring while this consent was in effect.**

### Consent for Treatment/Care

I consent to treatment and care by UNC Health affiliates and by their physicians and health care providers, including those who are located at sites other than the one at which I am present and who provide treatment and care through electronic communications/telemedicine. I also consent to treatment and care by physicians and health care providers who are not employees or agents of UNC Health affiliates (including but not limited to physicians and providers in the specialties of emergency medicine, anesthesia, surgery, pathology, psychiatry, obstetrics and gynecology, radiology, oncology, cardiology, neurology, pediatrics and internal medicine) but are authorized by UNC Health affiliates to provide treatment and care to me as a patient of the UNC Health affiliate, and who provide services to the UNC Health affiliates’ patients in accordance with their professional judgment. I understand that my treatment and care may include routine care, such as immunizations, and a variety of other medical services depending on my condition, such as laboratory testing. I can receive a list of services and care that I have received from UNC Health affiliates. I understand that my care team at UNC Health affiliates may include resident physicians and students or other trainees. I am aware that the practice of medicine (including surgery) is not an exact science, and no one has made any guarantees about the results of my treatments, examinations, or procedures.

### Consent for Use and Release of Information

I give permission to UNC Health affiliates – including their treating and referring providers and other staff members – to release any information about me, my health, the health services provided to me, or payment for my health services as permitted by law. For more detailed information about the way my information may be used or released, I can read UNC Health’s *Notice of Privacy Practices*.

I give permission to UNC Health affiliates and their employees, agents, and contractors to take photographs or make videos of me for permissible treatment, payment, health care operations, education and for research purposes where either I have given consent or an Institutional Review Board has approved as long as such recordings are consistent with policies and laws that protect my rights.

### Consent for Use Within UNC Health

I further give permission to UNC Health affiliates and their treating providers and other staff members to disclose to each other any of my sensitive information necessary for my treatment, including information related to behavioral and/or mental health (including records of my treatment by a facility whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of the mentally ill, developmentally disabled, or substance abusers, as defined by N.C.G.S. Chapter 122C, Articles 1 and 3), drugs and alcohol (including records of a provider that provides alcohol or drug abuse diagnosis, treatment, or referral, as defined by federal law at 42 C.F.R. Part 2), HIV/AIDS and other communicable diseases, and genetic testing.

### Financial Responsibility

I understand and agree that physician charges for medical and related professional services performed or supervised by a physician will be billed separately from hospital charges. I understand that my actual charges may be different from charge estimates given to me. I also understand that an insurance company may not pay the full amount of my charges, and I may be responsible (as a patient, spouse, guardian, or the parent of a minor child) for the amount not paid. If I do not have health insurance or have not provided current or accurate insurance information, I am responsible for payment of all charges. If I have overpaid any of my accounts with a particular UNC Health affiliate, I agree that the overpayment may be applied to pay any outstanding charges on any of my accounts with other UNC Health affiliates. I designate UNC Health as my authorized representative with respect to any health or liability insurance policy or any group health plan, fund or program applicable to me, and I authorize UNC Health to exercise on my behalf any grievance, claim or appeal rights, including external review rights, I may have under any such health or liability insurance policy or group health plan, fund or program.

### Medicare/Medicaid/Insurance Certification, Assignment & Payment Request

I have been informed that Medicare will only pay for services that it determines to be reasonable and necessary under section 1862(a)(1) of the Medicare Law. I certify that the information given by me or by my authorized representative in applying for



\* S D C O N A U T \*

payment for my health care under the Medicare or Medicaid programs is correct. I request that payment of authorized benefits be made to the appropriate UNC Health affiliate on my behalf. I authorize UNC Health affiliates to bill directly and assign the right to all health and liability insurance benefits otherwise payable to me, and I authorize direct payment to the appropriate UNC Health affiliate.

**Social Security Number**

I have given my social security number voluntarily. UNC Health affiliates may use it for accurate identification, filing insurance claims, billing and collections, and compliance with federal and state laws.

**Wireless Telephone Number and Electronic Mail**

UNC Health affiliates, or their agents or representatives, may contact me by electronic mail or telephone (including phone calls or text messages) at any electronic mail address or number contained in my UNC Health affiliate’s records, including wireless telephone numbers, for the purposes of communicating with me about my health care, servicing my account and collecting amounts due. I also understand that UNC physician researchers or members of their research team may also contact me via phone, or electronic mail to determine my interest in participating in human subject research. Methods of contact may include pre-recorded or artificial voice messages and text messages, and the use of automatic dialing services. I understand that I may revoke consent to receive communications via phone calls, text messages or electronic mail at any time by following the instructions in the communication or calling UNC Health Customer Service at (888) 996-2767.

**Personal Property**

Unless I am a resident of a skilled nursing facility, I understand that UNC Health affiliates do not assume responsibility for my personal belongings that I keep in my possession, and I release UNC Health affiliates from all liability for the loss or theft of, or damage to, such belongings.

**I UNDERSTAND THAT I MAY WITHDRAW THIS CONSENT IN WRITING. MY WITHDRAWAL WILL NOT BE EFFECTIVE FOR ACTIONS ALREADY TAKEN BY ANY UNC HEALTH CARE AFFILIATE, OR IN PROGRESS.**

**I AUTHORIZE UNC HEALTH CARE AFFILIATES TO RELEASE ALL RECORDS REQUIRED TO ACT ON THESE REQUESTS. I HAVE READ AND UNDERSTAND THIS FORM, BEEN OFFERED A COPY, AND I AM THE PATIENT OR I AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS FORM.**

\_\_\_\_\_  
DATE: \_\_\_\_\_ TIME: \_\_\_\_\_  
**PATIENT SIGNATURE (or Authorized Representative)**

\_\_\_\_\_  
PRINTED NAME

RELATIONSHIP, if not patient: \_\_\_\_\_

**GUARANTOR OF PAYMENT:** This line may be signed by someone who wishes to agree to be responsible for payment *other than*: 1) the patient, 2) the patient’s spouse, or 3) a minor patient’s parent.

By signing as guarantor below, I agree to pay all charges of any UNC Health Care affiliate not paid, **even if I am otherwise not legally obligated to pay.**

\_\_\_\_\_  
DATE: \_\_\_\_\_ TIME: \_\_\_\_\_  
**GUARANTOR OF PAYMENT SIGNATURE**

\_\_\_\_\_  
PRINTED NAME

