Today's Date: ________________
Account #: ________________

PATIENT REGISTRATION FORM

Address

Last Name:	First Name:	Middle Name:
Title: (circle one): Mr. Mrs. Miss Ms. **Generation:** (circle one): Jr Sr III Other _____		
Mailing Address:	**Street Address** (if different from mailing address)	

City:	County:	State:	Zip:

Demographics

Sex at birth: ☐ Male ☐ Female	**Marital Status:** ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated
Gender Identity: ☐ Male ☐ Female ☐ Trans-Man ☐ Trans-Woman ☐ Other ☐ Do Not Wish To Disclose	**Sexual Orientation:** ☐ Straight ☐ Gay/Lesbian ☐ Bisexual ☐ Don't Know ☐ Other ☐ Do Not Wish to Disclose
Social Security Number: - -	**Home Phone:**
Date of Birth MM/DD/YYYY: / /	**Alternate/Secondary Phone:**
Email:	**Cell Phone:**
Which phone number is your primary number? ☐ Home ☐ Alternate/Secondary ☐ Cell	

Account #: ________________

Additional

Race:

☐ White ☐ Black ☐ Asian ☐ American Indian

☐ Native Hawaiian ☐ Other

Ethnicity:

☐ Hispanic ☐ Non-Hispanic

Primary Language:

☐ English ☐ Spanish ☐ Other: ___________

Student:

☐ No ☐ Full-Time ☐ Part-Time

How did you hear about us?

☐ TV/Radio ☐ Magazine/Newspaper ☐ Social Media ☐ Google ☐ Billboard

☐ Friend/Family/Referral

Patient Profile

Family Size: __________ **Total Family Income: $**____________________ **per/ year**

Do you or your family with whom you live work as an agricultural worker? Yes ☐ No ☐

If YES, please tell us if you are a Migratory <u>or</u> Seasonal agricultural worker:

1. **Migratory Worker: Have you or a family member with whom you live moved in the past 2 years and established a *<u>temporary home</u>* to work in agriculture?**
   ☐ Yes ☐ No
2. **Seasonal Worker: Have you or a family member with whom you live worked in agriculture in the past 2 years without moving from your home?** Yes No ☐ ☐

Is your family currently homeless or displaced? ☐ Yes ☐ No

Are you a veteran? ☐ Yes ☐ No

Emergency Contact

Person to Contact in Case of Emergency:

Relationship to You:

Primary Phone #: _________________________ **Secondary Phone #:** ______________________

Account #: ________________

IF YOU DO NOT HAVE MEDICAL OR DENTAL INSURANCE, PLEASE SKIP TO THE NEXT PAGE.

MEDICAL INSURANCE

Primary MEDICAL Insurance Carrier:	**Policy #:**
Policyholder: ☐ **Self** ☐ **Other** If Other: Policyholder Name: ______________________ Relationship to Patient: ______________________ Policyholder Date of Birth: ______________________	**Group #:** **Effective Date:**
Secondary Medical Insurance Carrier:	**Policy #:**
Policyholder: ☐ **Self** ☐ **Other** If other: Policyholder Name: ______________________ Relationship to Patient: ______________________ Policyholder Date of Birth: ______________________	**Group #:** **Effective Date:**

DENTAL Insurance

Primary DENTAL Insurance Carrier:	**Policy #:**
Policyholder: ☐ **Self** ☐ **Other** If Other: Policyholder Name: ______________________ Relationship to Patient: ______________________ Policyholder Date of Birth: ______________________	**Group #:** **Effective Date:**
Secondary Dental Insurance Carrier:	**Policy #:**
Policyholder: ☐ **Self** ☐ **Other** If Other: Policyholder Name: ______________________ Relationship to Patient: ______________________ Policyholder Date of Birth: ______________________	**Group #:** **Effective Date:**

Account #: ________________

Parent or other legally authorized representatives must complete this section if patient is under age 18 and not legally emancipated.

Responsible Party

Responsible Party Last Name:	Responsible Party First Name:	Responsible Party Middle Name:

Mailing Address:	Street Address (if different from mailing address)

City:	County	State:	Zip:

Relationship to Patient:

Responsible Party Date of Birth:	Responsible Party Social Security Number:

I authorize Contentnea Health to provide health care services to the patient seeking care. I acknowledge my responsibility to ensure payment for the care according to fees established.

Signature of Responsible Party: ____

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION
I authorize the release of all information to my insurance company or other appropriate party, as required, related to treatment provided by Contentnea Health. Further, I authorize Contentnea Health to obtain needed information from my health insurance company and other health care providers.

CONSENT TO TREATMENT & FINANCIAL RESPONSIBILITY
I consent to all treatment prescribed by my health care provider and provided by Contentnea Health, its employees, or representatives. I understand I am ultimately responsible for charges related to my treatment. All accounts are due and payable upon receipt of the bill.

CONSENT TO RECEIVE TEXT/EMAIL NOTIFICATIONS
I consent to receive text/email notifications and understand that I can opt-out or update my communication preferences at any time.

NOTICE OF PRIVACY PRACTICES
I acknowledge that I have been given the Notice of Privacy Practices by Contentnea Health.

ASSIGNMENT OF BENEFITS
I authorize and direct my insurance providers to issue payment directly to Contentnea Health for health care services provided to me and/or my dependents. I understand that I am responsible for deductibles, copays and any amount not covered by insurance.

My signature below attests that all information provided is true and accurate to the best of my knowledge and that I understand the rights and responsibilities above.

Signature:	Date:

Account #: ___________________

Notice of Privacy Practices

This notice describes how your health information may be used or disclosed and how you can get access to this information. Please review the Privacy Notice and acknowledge your receipt of the document.

Our duty: It is Contentnea Health's legal obligation to safeguard your protected health information (PHI). We are required by law to provide you with a Privacy Notice detailing our legal duties and privacy practices with respect to PHI and to abide by the terms of this Privacy Notice currently in effect. If you decline to acknowledge this notice, you understand that Contentnea Health may still use and disclose your PHI.

Changes to this notice. We reserve the right to change this Privacy Notice at any time and make the new notice provisions effective for all PHI we maintain. If we make changes, we will post a copy at our facilities and on the company website at https://contentnea.org/

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Federal law requires us to protect the privacy of your PHI. State law can restrict the disclosure and use of your information in many instances. However, we may disclose and use your health information under Federal and State law for treatment, payment, and health care operations; pursuant to a court order; or as otherwise permitted or required by law.

NC and Federal Law allow us to use and disclose your PHI without your written permission as follows:

To provide health care treatment to you: We may need to use and disclose your PHI to provide, coordinate or manage your health care and related services. This may include communications with other health care providers regarding treatment and coordination of care. For example, we may need to use or disclose your PHI, both inside and outside of Contentnea Health, when you need a prescription, lab work, an x-ray or other health services. In addition, we may need to use or disclose your PHI when referring you to another physician.

To obtain payment for services: We may use or disclose your PHI to others to bill and collect payment for treatment and services provided to you. Before you receive scheduled services, we may need to share information about these services with your health plan(s). Sharing information allows us to ask for coverage under your health plan or policy and for approval of payment before we provide the services. We may also need to share PHI with the following:

- Collection departments or agencies, or attorneys assisting with collections, including the state of NC Office of the Attorney General.
- Insurance Companies, health plans and their agents
- Others responsible for your bills, such as your spouse or guarantor, as necessary to collect payment.

For health care operations: We may use and disclose your PHI to perform health care operations that allow us to improve the quality of care we provide and reduce health care costs. We may use your PHI for our own health care operations. In addition, we may need to disclose your PHI for the health care operations of other providers involved in your care to improve quality, efficiency, and costs of their care, or to evaluate and improve the performance of the providers. For example: members of clinical staff, the risk management team, or quality improvement team, may use the information in your health record to assess the quality of care you receive and the outcomes of your treatment at our facilities. We may also disclose your information to doctors, nurses, medical students, and other Contentnea Health personnel for review and teaching purposes.

Appointment reminders/scheduling: We may use and disclose your PHI to contact you as a reminder of an appointment with Contentnea Health

We may use and disclose your PHI under other circumstances without your authorization or opportunity to agree or object:

- When necessary to prevent or lessen serious threats to your health and safety or the health of the public or another person.
- To authorized officials when required by federal, state, or local law. Ex: Reporting abuse or neglect of a child or disabled person or reporting specific types of wounds and injuries.
- To law enforcement in the event of a crime.
- In response to subpoenas, court orders, or administrative orders.
- As required by law for public health activities. Ex: preventing or controlling disease and reporting births or deaths.
- For authorized Worker's Compensation activities.
- To health oversight agencies that ensure compliance with licensure and accreditation requirements.
- To coroners, medical examiners, or funeral directors to carry out their duties.
- As required by military command authorities, if you are a member of the armed forces.
- To our business associates to carry out treatment, payment, or health care operations on our behalf. Ex: We may disclose your PHI to a company that performs our lab work, or an associate that bills insurance companies for our services.
- To a correctional institution having lawful custody of you as necessary for your health and safety of others.
- For research to collect information in databases to be used later. We may disclose your PHI, and surplus specimens, for research approved by an institutional review board that has determined your written consent is not required. We may also review your PHI to determine if you are eligible for a medical research study or to allow a researcher to contact you via phone, email, text, or mail to determine if you are interested in participating in a medical research study.
- **We may contact you:** If you have provided us with a phone number or email address, we may use this information to contact you to manage your care, make you aware of services that may benefit you, or to discuss your bill. Medical researchers may also use this information to contact you if they feel you would be an ideal candidate for a medical research study.
- **Health Information Exchange *(HIE):*** An HIE allows our providers to share your health information with other health care providers, treating you to access and share your information if they also participate in the HIE.

You can object to certain uses and disclosures: Unless you object, we may use or disclose your PHI in the following ways:

- **We may share your location in our facilities and general condition** (serious, critical, etc.) in our patient listing with people who ask for you by name. We may share your religious affiliation with clergy.
- **Individuals involved in your care or payment of your care.** We may share your information with a family member, personal representative, friend, or other person you identify when information is related to their involvement in your care or payment for your care.
- **Emergency circumstances and disaster relief.** We may share your PHI with public or private agencies for disaster relief purposes. Even if you object, we may still share PHI if necessary for emergency circumstances. In an emergency, or if you are unable to make decisions for yourself, we will use our professional judgement to decide if it is in your best interest to share your PHI with a person involved in your care.

Uses and disclosures of your PHI that require your written permission: We will obtain your authorization in the event we may seek to:

- Use or disclose psychotherapy notes
- Use or disclose your PHI for marketing purposes
- Sell any of your PHI

Account #: ________________

We will obtain your authorization for any use/disclosure of your PHI not otherwise described in this Notice of Privacy Practices. **If you authorize us to use or disclose your PHI, you may revoke this authorization, in writing, at any time. If you revoke this authorization, we will no longer use or disclose your PHI for the purpose(s) covered by your written authorization. However, we cannot take back any disclosures already made pursuant to a valid authorization.**

Privacy Protections for Alcohol, Drug Abuse, and Psychiatric Treatment: We will not release or disclose any health information identifying you as a patient of one of our programs or facilities, or disclose information related to your treatment in such a program or facility, unless:

- You or a personal representative consent in writing
- A court order requires the disclosure
- Clinical personnel need information to treat you in a medical emergency
- Qualified personnel utilize the information for research or operational activities
- It is necessary to lessen or prevent a crime or a threat to commit a crime
- It is necessary to report abuse or neglect as required by law

Minors: According to North Carolina Law, minors, with or without the consent of a parent or legal guardian, have the right to consent to services for the prevention, diagnosis, and treatment of specific illnesses including venereal disease (STIs), pregnancy, abuse of controlled substances or alcohol; and emotional disturbance. If you are under the age of 18, are not married, have not been legally emancipated, or have joined the armed forces, you can consent to treatment for venereal disease (STIs), pregnancy, abuse of controlled substances or alcohol, and emotional disturbance without an adult's consent. This information will remain confidential, unless your provider believes telling your parents will prevent a serious threat to your life or health. Please note: Minors must get parental or court consent for an abortion or sterilization procedure.

YOUR RIGHTS WITH YOUR PHI

Request restrictions: You have the right to request that we restrict the use and disclosure of your PHI for treatment, payment, or health care operations; for us in our health center or facility directory; or to family and others involved in your care. However, we are not required to agree to your requested restrictions in most circumstances. If we agree to your request, then we will comply unless the information is needed to provide emergency services or is required to be disclosed by law or as otherwise described in this Privacy Notice. If you pay in advance and in full for certain items and services and request that we do not disclose these items or services to your health plan, we will comply. Requests for restrictions must be in writing and given to the clinic at which you receive treatment.

Request different communications: You have the right to specify how you want us to communicate with you in writing. For example, you can specify which phone number or email address you prefer us to use for primary point of contact when discussing your PHI. We will accommodate all reasonable requests, but we may ask you to provide additional information about how payment will be handled and for alternative addresses.

A copy of your PHI: You have a right to request to view and receive a copy of your PHI that is part of clinical, billing, and other records that are used to make decisions about you and your care. You must request to view your PHI in writing and make the request to the clinic at which you receive treatment. The clinic will provide you with the form that you can sign and return. We may charge a fee for copying or mailing your request. In some circumstances, we may deny your request. You have a right to appeal the denial.

Request Amendments of your PHI: If you think your PHI and billing information are incomplete or inaccurate, you may ask us to correct it. We may deny your request in the following circumstances:

- The information was not created by us
- The information is not part of the records we use to make decisions about your care
- We believe that the information is correct and complete
- The request pertains to a part of the record you do not have the right to review

Please submit all requests in writing and explain the reason(s) for the request. If we deny the request, we will provide you with the reason for denial and describe your rights to dispute the denial. If we accept the amendment, we will make reasonable efforts to alert other individuals of the amendment. An amendment form will be provided to you upon request at your clinic. Please sign and return the form to the facility in which you receive treatment.

Request a listing of certain disclosures of your PHI we have made: You have a right to receive a written list of certain disclosures we have made with your PHI. You may ask for disclosures up to 6 years before your request. We are required to provide a list of all disclosures except in the following scenarios:

- For your treatment
- For billing and collections related to your treatment
- For health care operations
- Made to or requested by you, or that you authorized
- Incidental to permitted uses and disclosures
- Made to individuals involved in your care, for directory or notification purposes
- Allowed by law when the use/disclosure relates to specialized government functions or to correctional institutions
- As part of a limited set of information that does not identify you as an individual

This list will include the date of disclosure, name and address of the individual receiving the information, and a summary of the information disclosed, as well as the purpose of the disclosure. To request a listing of disclosures, please contact our **Privacy Officer at (252)747-8162.**

Right to breach notification: You have a right to receive notice of a breach of your PHI.

Right to receive a copy of this notice: You have a right to request a paper copy of this Privacy Notice at any time. Our Privacy Notice is posted at all our clinic sites and on our website: **https://contentnea.org/**. We will provide you with this Privacy Notice no later than the date you first receive treatment or services with our facilities, except for in an emergency.

CONTACT US FOR QUESTIONS OR COMPLAINTS

If you need more information relating to our privacy practices, or if you think we have violated your privacy rights, you can contact our Privacy Officer at:

Contentnea Health Administrative Office
Contentnea Health
7 Professional Drive
Snow Hill, NC 285580
Phone: **(252)747-8162**

We take great pride in protecting patient privacy within our organization. However, if you feel we cannot resolve your complaint, you may file a complaint to the United States 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/**.

If you are receiving this notice as a new patient or authorized representative, please sign the acknowledgement of receipt ____ Date: ____________

Account #: ________________

Fax all requests to (252)513-2643

Authorization to Release Protected Health Information (PHI)

Patient Information	Patient Name: ____________________________ DOB: ____________ Address: ____ City: ______________ State: ______ Zip: ________ Phone #: ______________
Please list the specific organization or provider who has the information you want to be released	Organization or Provider Name: ____________________________________ Address: ____ City: ____________ State: ______ Zip__________ Phone #: __________________ Fax #: __________________
Where do you want the information to be disclosed or released to?	Name of organization or class of persons receiving the requested information: ____________________ Address: ____ City: ____________ State: ________ Zip: __________ Phone #__________________ Fax # __________________
Information to be released check appropriate box and initial: Please check appropriate boxes and indicate dates of service: **Notice: X-Ray images must be sent via email and cannot be faxed**	☐ Entire Medical Record Dates of service: __________ ☐ Dental X-Ray Images/Reports Dates of service: __________ ☐ Lab Reports Dates of service: __________ ☐ Billing/Insurance Info Dates of service: __________ ☐ Prescriptions Dates of service: __________ ☐ History and physical exam Dates of service: __________ ☐ Other (please specify) ________________ Dates of service: __________ Initial: ________
Purpose for the requested disclosure:	☐ At the request of the individual ☐ Continuity of care ☐ At the request of the parent/legal guardian of the individual ☐ Changing Providers ☐ Other (Legal, educational planning, billing) Specify: ______________________________
Release instructions: How do you want the information disclosed to the receiving party? Who do you want to pick it up if not you?	1. Release records by: ☐ In-person pickup ☐ Mail ☐ Email ☐ Fax 2. If in-person pickup, the person picking up the records is the? Check the applicable box ☐ Patient ☐ Family/Friend/Parent ☐ Legal representative Name of person picking up record: ______________________Relationship to patient: ______________ 3. **Contentnea Staff** please verify identity of individual and ensure there is documentation we can release the records to this individual in the health record. Use PHOTO ID\, BANK CARDS, MILITARY ID to verify
Release of sensitive health information: Please read	The health information released may contain information related to Mental/Behavioral health, Alcohol or Drug Abuse, HIV or AIDS, Sexually Transmitted Infections, or Family Planning. Please check whether to release information related to these conditions or to not release and initial. **Notice: A signature is required for patients that are minors to release sensitive information regarding the conditions listed above.** ☐ **To release** ☐ **Not release** **Signature of minor (13-17 years old) or signature of patient 18 years and older**__________________________

I understand I have the right to revoke this authorization at any time. My revocation must be in writing to Contentnea Health or to another provider to whom this permission release is granted. I am aware that my revocation is not effective to the extent that the person I have already authorized to use/disclose my health information has acted in reliance upon this authorization. I understand that I do not have to sign this authorization, and that Contentnea Health may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I further understand that if the person, organization, or agency authorized to receive this information is not a health plan or healthcare provider, the released information may be re-disclosed and would no longer be protected by federal or state privacy regulations. I agree that a copy of this release shall be as valid as the original. If I authorize Contentnea Health to fax/email this information, I realize there will be inherent risks of nonauthorized disclosures to these delivery methods. I understand a fee will be charged to cover the costs of copying these records. This authorization expires one year (365 days) from the date of this release.

Signature of Patient: ____________________ Date: ________ Signature of Parent or Legal Guardian if patient is <18 ______________ Date: ________