



Gaston Women's Healthcare

CaroMont Medical Group

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WELCOME TO GASTON WOMEN'S HEALTHCARE

Patient Name: _____ Date: _____
(Last) (First) (MI)

Mailing Address: _____

Phone: () _____ Cell: () _____
****Number you prefer to be reached at: ___ Home ___ Cell

DOB: _____ Age: _____ SS#: _____

Marital Status (Circle One): Single Married Divorced Widowed Separated

Employer: _____ Length of Employment: _____

Employer Address: _____

Employer Phone: () _____

Driver's License #: _____ State: _____

Responsible Party Name: _____

Relationship to Patient: _____

Mailing Address: _____

Phone: () _____ SS #: _____

Employer: _____ Length of Employment: _____

Employer Address: _____

Employer Phone: () _____

Name of Spouse: _____ DOB: _____ Age: _____

SS #: _____ Occupation: _____

Employer: _____ Length of Employment: _____

Employer Address: _____

Employer Phone #: () _____

Emergency Contact: _____ Relationship: _____

Home/Work Phone #: _____ Cell: _____

How did you hear about Gaston Women's Healthcare? _____

Referred by: Dr. _____

TURN OVER AND COMPLETE OTHER SIDE

INSURANCE INFORMATION

Patient Name: _____

PRIMARY INSURANCE CARRIER

Name of Insurance Company: _____

Insured's Name: _____ DOB: _____

Policy/Certificate #: _____ Group #: _____

Effective Date of Coverage: _____

ACKNOWLEDGEMENT OF RECEIPT – NOTICE OF PRIVACY PRACTICE

Our "Notice of Privacy Practices" document provides detailed information about the use and disclosure of my protected health information. I have the right to review the "Notice of Privacy Practices" document prior to signing this consent form. GWHC encourages you to read our Notice of Privacy Practice in full.

Our "Notice of Privacy Practices" document is subject to change. You can obtain a copy of the current notice by requesting that a revised copy be sent to you in the mail or given to you in person.

I, AS THE PATIENT OR THE PATIENT'S PERSONAL REPRESENTATIVE, HAVE RECEIVED A COPY OF GWHC'S "NOTICE OF PRIVACY PRACTICES" DOCUMENT. If this acknowledgement of receipt is not obtained (i.e. emergency treatment situation), GWHC's representative (witness) MUST document his/her good faith efforts to obtain the acknowledgement and the reason the acknowledgement was not obtained.

Signed: _____ **Date:** _____
(Signature of Patient, Personal Representative of Patient, or Legal Guardian of Patient)

Good faith effort and reason acknowledgement was not obtained:
_____ Patient refused to sign _____ Patient unable to sign _____ Other: _____

This form applies for services provided by all affiliates of CaroMont Health (CH) as listed below: Gaston Health Care, Incorporated, d.b.a. CH; Gaston Memorial Hospital, Incorporated (GMH) and GMH d.b.a. CaroMont Psychiatric Center; Gaston Health Service, Inc. and Gastoi Services d.b.a. CaroMont Health Services and d.b.a. Courtland Terrace and d.b.a. The Diagnostic Center and d.b.a. CaroMont Specialty Surgery and d.b.a. CaroMont Imagin Services; CaroMont Medical Group, Inc. (CMG) and d.b.a. CaroMont Family Medicine and d.b.a. CaroMont Pediatric Partners Associates and d.b.a. CaroMont Psychiatric Associates and d.b.a. CaroMont Urgent Care and d.b.a. Endocrinology Associates and d.b.a. CaroMont Inpatient Physicians and d.b.a. Gaston Perinatal Center and d.b.a. CaroMont Specialty Group and d.b.a. Gaston Women's Healthcare.

PERSONAL REPRESENTATIVE AUTHORIZATION

*A personal representative is anyone that you would like for GWHC to release your patient information to, including, but not limited to, prescription refills and /or samples, reasons for a particular visit, billing information, etc. **If there are no names listed below we are assuming that you are declining your option to choose a personal representative. Upon doing so, please keep in mind that our office will not give out any information, including prescription refills, to anyone other than the patient or patient guardian.***

I do not wish to select a personal representative I authorize the following individual (s) to serve as my/patient's Personal Representative with full authority to access or authorize review, release and/or copying of my/patient's medical records: 1) _____ 2) _____

3) _____ 4) _____

I may revoke this request in writing, at any time except to the extent that action based on this authorization has already taken place.

Signed: _____ **Date:** _____
(Signature of Patient, Personal Rep. of Patient, or Legal Guardian of Patient)