Granville Heart & Vascular

103-C Professional Park Drive

Oxford, North Carolina

(919) 690-8853 Phone

(919) 690-8866 fax

Thank you for choosing Granville Heart & Vascular. Enclosed you will find our new patient registration packet. **Your appointment with Dr. Pacca is scheduled for:**

*****If you are unable to keep this appointment, please contact our office at least 24 hours prior to the appointment date to cancel or reschedule.**

Our automated attendant makes appointment reminder calls 2 days prior to your scheduled appointment.

*****Missed appointments without notification may be subject to a fee.*****

- Please bring the completed forms, your insurance card, driver's license, and ALL of your medications with you to this consultation appointment.
- You will be expected to pay your copay at the time of your appointment. *(Specialist copay is listed on your insurance card).*
- We are located at 103-C Professional Park Drive:

1. Turn into the main entrance of Granville Medical Center.
2. Take the second driveway on the right.
3. Proceed up the hill; Before you reach the stop sign, take the second left into our parking lot.
4. Our entrance is the second door – 103 C
5. The window on the far right of the waiting room is where you will register/check-in.

If you have any questions about these forms, please ask the receptionist or doctor before you leave from your appointment.

Hours of Operation:

Monday – Thursday 8:00am – 5:00 pm Friday 8:00am – 12:00pm

By Appointment Only

GRANVILLE HEALTH SYSTEM

PATIENT PAYMENT POLICY

Patients with health care insurance:

- We will happily file your claim with your insurance carrier. If you have secondary insurance we will file both insurance claims.
- Patients who have Medicare only will be required to pay their 20% co-insurance and/or deductible.
- Patients who have Medicaid will be required to pay their co-pay for hospital stays and this will be collected at the first office visit after hospitalization.
- Patients with unpaid balances will be ask to pay the balance or set up a payment plan. We reserve the right to reschedule your appointment for non-payment.

Patients without health care insurance:

- If you have no insurance we offer medical care for the same fee as NC Medicaid and payment is required at time of visit.

Patients will be required to pay their co-pay, co-insurance and/or deductibles at the time of their visit.

www.ghsHospital.org

Granville HEALTH SYSTEM

Quality Care...Close To Home

Find us on facebook.

QUALITY CARE IN YOUR NEIGHBORHOOD

Granville Heart & Vascular
Late Arrival Notice

If you are an established patient and you arrive 15 minutes late or more to your appointment you will likely be asked to reschedule unless the physician's schedule can still accommodate you.

Priority will be given to the patients who arrive on time and you may have to be worked in between them. This may mean you will have a considerable wait. If this is not convenient for you, you may choose to reschedule.

Likewise if you are a new patient and you arrive at the scheduled appointment time and not early to complete your forms as instructed and it takes more than 15 minutes to complete the forms and the registration process, you may also be asked to reschedule.

One or two late patients cause the entire daily schedule to fall behind. This is an inconvenience to everyone. Emergencies do arise but we strive to see every patient as close to their appointment time as possible.

Thank you.

GHI SPECIALIST PRACTICES
CANCELLATION AND NO SHOW
POLICY STATEMENT

- We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours' notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours' notice, we are unable to offer that time-slot to other patients.

- Office appointments which are cancelled with less than 24 hours notification and patient "no-shows", may be subject to the following cancellation fee schedule:

    - First missed office appointment:
        - No charge as courtesy.
    - Second missed office appointment:
        - $25 fee will be billed to the patient's account.
    - Third and subsequent missed office appointment:
        - $50 fee will be billed to the patient's account.

- Procedure cancellations require 3-business day advance notice. Procedure cancellations with less than 3 days' notice and all procedure "no shows" may be subject to a $75.00 cancellation fee.

- The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

- We understand that Special unavoidable circumstances may cause you to cancel within 24 hours. Patient's requests for waivers of fees may be submitted to the Director, Physician Practices for review and consideration.

- Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to the Director, Physician Practice (919) 690-3180.

Please sign that you have read understand and agree to this Cancellation and No show Policy.

_____ _____

Patient Name (Please Print) Date of Birth

_____ _____

Signature of Patient or Patient Representative Date

Attachment (1)

Granville Heart & Vascular

103 C Professional Park Drive

Oxford, North Carolina 27565

(919) 690-8853 phone

(919) 690-8866 fax

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that a copy of the Notice of Privacy Practices has been provided to me. The notice contains information regarding potential uses and disclosures of my protected health information (as that term is defined under the Health Insurance Portability and Accountability Act of 1996 "HIPPA") that may be made by Granville Heart & Vascular, and of my rights and Granville Heart & Vascular' s legal duties with respect to my protected health information. I have had the opportunity to review the Notice and take a copy with me if I so choose.

_____

Patient Name

_____

Patient Signature

Disclosure Authorization:

I give permission that Granville Heart & Vascular may:

- ☐ Leave a detailed message on my home/cell answering machine/voicemail
- ☐ Leave a detailed message with my spouse
- ☐ Call my workplace phone number & leave a message_____(phone #)
- ☐ May discuss my condition(s) with _____

  _____
- ☐ None of the above

Granville Heart & Vascular

103 Professional Park Dr

Oxford, NC 27565

919-690-8853 919-690-8866

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____

Medical Record # :_____ Date of Birth: _____

☐ I authorize _____to Release information for patient care to Granville Heart & Vascular to the address listed above.

☐ I authorize _____ to Obtain information for patient care from Granville Heart & Vascular.

The specific information includes the following dates of service: _____

Purpose of this Release:

☐ Continued Medical Care ☐ Legal ☐ Insurance ☐ Personal Use

Information to be Release/Obtained :

☐ Comprehensive Record ☐ Laboratory Results ☐ Office Visit Note

☐ Immunization Records ☐ Radiology Reports ☐ Operative Reports/Procedure Note

☐ All ☐ Other : _____

I hereby authorize the use and/or disclosure of my individually health information as described above. I understand that this authorization is voluntary. NO individual has coerced me into signing this authorization, and I am providing this authorization under my own free will. I understand that once this information is received by the authorized organization or person, then it may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws. I understand that the person(s) or organization (s) authorized to make the requested use and/or disclosure may not condition treatment, payment, enrollment or eligibility for benefits, on my executing this authorization.

I acknowledge that I have the right to revoke this authorization. I understand that my revocation must be in writing. I also understand that my revocation will be valid except to the extenet that the person (s) or organization (s) authorized to make the requested use and/or disclosure have taken action in reliance of this authorization, or if this authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself. This authorization will expire on the following date: _____

_____ _____

Patient Signature Date

Granville Heart and Vascular

103 Professional Park Dr. Ste. C

Oxford, NC 27565

Richard Pacca, MD

919-690-8853 phone

919-690-8866 fax

Health History — Confidential

Name: _____ Birth Date: _____ Date: _____

Height_____ Weight:_____

Primary Care Doctor: _____

Do you see any other doctors? Yes _____ No _____

Doctors Name: Reason you see this doctor:

_____ _____

_____ _____

Who is your eye Doctor? _____ Phone: _____

Who is your Dentist? _____ Phone: _____

What is your primary language? English _____ Other: _____

Do you have a Living Will? No _____ Yes _____ *(Please provide a copy)*

Who may we give out your medical information to?

Spouse _____ Parents _____

No One _____ Other _____

Why are you coming to see the doctor? _____

_____

Do you take aspirin daily: Yes _____ If so how many _____mg No _____

Do you have an allergy to iodinated contrast or seafood? Yes _____ No _____

Do you have an allergy to aspirin? Yes ___ No __ If yes, what is reaction _____

List Medication Allergies you have: ❑ I do not have any medication allergies.

Medication	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

Please list **any Previous Surgeries:** ❑ I have never had surgery

Procedure	Date
_____	_____
_____	_____
_____	_____

Do you smoke? Yes _____ No _____

If yes, how many packs per day _____ For how many years? _____

Did you used to Smoke? If you quit, how many years ago? _____

Do you drink Alcohol? Yes _____ No _____

If yes, how many drinks do you have? 1-2 _____ 3-5 _____ >5 _____

Do you take any street drugs specifically cocaine or marijuana? Yes _____ No _____

If yes, which one _____

Do you have any family history (mother, father, siblings, or children) of heart attacks, congestive heart failure, or strokes before the age of 65? Yes _____ No _____.

If yes, fill in further details on the next page:

Family Member	Disease and age first discovered

Please **Circle** if you have had any of the following symptoms in the last six months:

General: Fatigue Night Sweats Weight Gain Weight Loss:

Eyes/Ears/Nose/Throat: Blurry Vision Double Vision Ringing in Ears Nose Bleeds

Respiratory: Cough Shortness of breath Wheezing Spitting up Blood

Cardiovascular: Chest Pain Leg Swelling Dizziness Heart Racing

Gastrointestinal: Abdominal Pain Heartburn Nausea Vomiting Rectal Bleeding

Urinary: Blood in urine Frequent Urination Kidney Stones

Musculoskeletal: Joint Pain Muscle Weakness Leg Pain with Walking

Neurological: Weakness in arms or legs Numbness or Tingling in arms or Legs Headaches

Psychiatric: Anxiety Depression Panic Attacks

Hematology/Endocrine: Bruising easily Excessive Hunger/Thirst Heat or Cold Intolerance

Reproductive: Erectile dysfunction Vaginal Bleeding

Dermatology: Hives Itching Rash

Childhood Diseases: Rheumatic Fever Scarlet Fever

Granville HEALTH SYSTEM
Quality Care...Close To Home

Granville Health System, Physician Practices

Patient Registration/Consent Form

Patient Centered Medical Home

PREFERRED PHARMACY INFORMATION

(Please print clearly, all information requested below)

PHARMACY: | Phone Number:

PATIENT INFORMATION

Last Name | PHONE CONTACTS: Home # | Work # | Cell #

First | MI | SSN: | Sex: ☐ Male ☐ Female | Birth Date:

Address 1: | Marital: ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced | Employment: ☐ Full Time ☐ Part Time ☐ Self ☐ Not ☐ Retired ☐ Military

Address 2:

City: | State: | **Preferred E-Mail:**

Zip Code:

(PCP) Primary Care Provider/Physician: | Name of Practice/Office/Group: | Phone #:

Race:
☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander
☐ Black/African ☐ American Indian/Alaska native ☐ White
☐ More than one race

Ethnicity:
☐ Hispanic ☐ Non-Hispanic
☐ Choose not to report

Preferred Language:
☐ English ☐ Spanish ☐ Other: _____

Preferred method of contact with you:
☐ Phone ☐ E-Mail ☐ My Health Electronic Portal

Learning Preference:
☐ Visual ☐ Voice ☐ Read

Dominant hand:
☐ Right ☐ Left ☐ Both

INSURANCE INFORMATION

(Please Provide Your Insurance Card to the Receptionist for Copying)

I have ☐ PRIMARY Insurance ☐ SECONDARY Insurance

I ☐ Have my insurance card(s) today
I ☐ DO NOT have my insurance card(s) today

☐ I DO NOT have insurance and understand that a SELF-PAY pre-payment may be required

I am ☐ insured by a policy in my name (I am Subscriber)
I am ☐ insured by a policy in someone else's name (I'm NOT Subscriber)

Subscribers name on card (If other than you) | Subscriber Date of Birth:

Relationship to Guarantor:
☐ Self ☐ Spouse ☐ Child ☐ Other

WORKER'S COMPENSATION CLAIM INFORMATION

Employer (Company) Name: | Supervisor: | Phone Number:

Claim #: | Workers Comp. Insurance Carrier: | Date of injury:

EMERGENCY CONTACTS

(Local friend or relative not living at same address)

1st Emergency Contact:	Relationship to Patient:	Address:	Home Phone #:	Cell or Work #:
2nd Emergency Contact:	Relationship to Patient:	Address:	Home Phone #:	Cell or Work #:

The information provided by me above, is true and accurate to the best of my knowledge. I hereby authorize the Medical Provider(s) and/or staff member(s) of Granville Health System's Outpatient Practices to administer any treatment, medical or surgical, considered necessary or advisable, to diagnose and/or treat my condition(s). The diagnostic/treatment process may require/include radiological and/or laboratory testing, administration of local anesthesia and/or the administration of medications. I authorize the release of my personal health information to my active insurance carrier(s) for the sole purpose of determining payment by said carrier(s) for covered services rendered by Granville Health System. I authorize and request payment by my insurance carrier, on my behalf, to Granville Health System, for any/all covered services provided to me. I also fully understand and assume full responsibility for any unpaid balances due for services provided me. In addition, I authorize Granville Health System, pursuant to its agreement with Granville Health Inc., to apply any refundable charges to outstanding patient accounts with either Granville Health System or Granville Health Inc., for which I have accepted responsibility as guarantor. I acknowledge that I have reviewed and understand the Health Information Portability and Accountability Act (HIPAA) Notice of Privacy Practices. I hereby provide Granville Health System permission to use my mobile phone number to communicate with me regarding my treatment, services rendered and or scheduling by live or recorded means. By providing Emergency Contact information, you are giving authorizing Granville Health System staff to notify the contact and advise them of your location only unless you directed otherwise. Granville Physician Practices WILL NOT disclose or share any of your personal medical information without your separate consent.

_____ _____

Patient / Guardian Signature *Today's Date*