

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 _____

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.¹ 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-sensitive² information regarding my health care or payment for my health care.

OR

Only these things:

<input type="checkbox"/>	My appointments – scheduling & reminders	<input type="checkbox"/>	My test results
<input type="checkbox"/>	My after visit summary (AVS)	<input type="checkbox"/>	My bills
<input type="checkbox"/>	Other: _____		

Name: _____ Phone Number: _____

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

Any non-sensitive² information regarding my health care or payment for my health care.

OR

Only these things:

<input type="checkbox"/>	My appointments – scheduling & reminders	<input type="checkbox"/>	My test results
<input type="checkbox"/>	My after visit summary (AVS)	<input type="checkbox"/>	My bills
<input type="checkbox"/>	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): _____

¹ 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.

² 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.**





Patient Label Here

GENERAL CONSENT FOR TREATMENT (PAGE 1 of 6)
HIM #129s

I understand that the University of North Carolina Health Care System (UNC Health Care) is an integrated health system made up of various entities, including (but not necessarily limited to) UNC Hospitals; Rex Hospital, Inc.; Caldwell Memorial Hospital, Incorporated; Chatham Hospital, Inc.; Henderson County Hospital Corporation d/b/a Margaret R. Pardee Memorial Hospital; the University of North Carolina at Chapel Hill, School of Medicine; Johnston Health Services Corporation; Nash Hospitals, Inc.; Nash MSO, Inc.; NHCS Physicians, Inc. ; UNC Rockingham Health Care, Inc.; Wayne Memorial Hospital, Inc. d/b/a Wayne UNC Health Care ; Wayne MRI, LLC; UNC Physicians Network, LLC; and UNC Physicians Network Group Practices, LLC (each referred to in this form as a “UNC Health Care affiliate” or collectively as “UNC Health Care affiliates”). **This consent will be effective for 1 year after the date I sign it at any UNC Health Care 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 Care 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 Care affiliates but are authorized by UNC Health Care affiliates to provide treatment and care to me as a patient of the UNC Health Care affiliate. I am aware that the providers listed on Exhibit A to this consent are independent contractors of UNC Health Care affiliates, as listed, and they provide services to the UNC Health Care affiliate’s patients in accordance with their professional judgment. The providers listed on Exhibit A are not employees or agents of the UNC Health Care affiliate. 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 from my health care provider. I understand that my care team at UNC Health Care 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 Care 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, that may be necessary: (1) for my treatment (to health care providers or facilities that need the information for my continued care); (2) for any purposes related to payment by me or a third party for services (to determine eligibility, to process an insurance claim, for utilization and quality review, or for billing or collection purposes, as necessary to obtain payment); (3) for the health care operations of the UNC Health Care affiliate or another health care provider that has had a relationship with me (quality assessment, training programs, planning, and fundraising); or (4) as otherwise described in the Notice of Privacy Practices and as permitted by law.

For more detailed information about the way my information may be used or released, I can read UNC Health Care’s *Notice of Privacy Practices*.

I give permission to UNC Health Care affiliates and their employees, agents, and contractors to take photographs or make videos or drawings of me for permissible treatment, payment, or health care operations purposes (which may include quality assessment, education, and training), as long as consistent with policies and laws that protect my rights.

Consent for Use Within UNC Health Care

I further give permission to UNC Health Care 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, 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 Care affiliate, I agree that the overpayment may be applied to pay any outstanding charges on any of my accounts with other UNC Health Care affiliates.

I further authorize release of financial information and activity related to payment for services to:

Name of Individual: _____

Relationship to Patient: _____

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 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 Care affiliate on my behalf. I authorize UNC Health Care 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 Care affiliate.

Social Security Number

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

Wireless Telephone Number

UNC Health Care affiliates, or their agents or representatives, may contact me by telephone at any number contained in my UNC Health Care 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. 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 this consent at any time by calling or writing to UNC Health Care.

Personal Property

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

Patient List

As a convenience to patients and visitors, UNC Health Care affiliates may keep a list of patients currently receiving services at a facility so that they may provide the location of the patient in the facility and the patient’s general condition to people who ask for patients by name. Unless I have initialed below, I give permission for UNC Health Care affiliates to give my location and general condition to individuals who ask for me by name.

_____ (*initial*) I do not want to be included in UNC Health Care affiliates’ patient lists. Please remove my name.

Religious Information

UNC Health Care affiliates may provide a patient list for community clergy when they request it. This list includes the name and location of the patient, the patient’s general condition, and the patient’s religious affiliation. Unless I have initialed below, I give permission for UNC Health Care affiliates to give my name, location, general condition, and religious affiliation to community clergy who request it.

_____ (*initial*) I do not want to be included in UNC Health Care affiliates’ list provided for clergy. Please remove my name. I understand that those employed by a UNC Health Care affiliate as chaplains may still obtain this information.

Sharing Information with Family and/or Friends

As a courtesy, limited health information may be shared with family and friends under the following conditions: (1) the information is related to that individual’s involvement in the patient’s care or payment for care, or (2) the information is needed to notify individuals responsible for the patient’s care about the patient’s location, general condition or death. Unless I have initialed below, I give permission for limited health information to be shared with my family and friends under the conditions mentioned above.

_____ (*initial*) I do not want personal health information shared with family or friends.

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, RECEIVED A COPY, AND I AM THE PATIENT OR I AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS FORM.

PATIENT SIGNATURE (or Authorized Representative) DATE: _____ TIME: _____

PRINTED NAME

RELATIONSHIP, if not patient: _____

GUARANTOR: If I sign below as guarantor (not as the patient, or spouse of the patient, or the parent of a minor child), I agree to pay all charges of any UNC Health Care affiliate not paid, **even if I am otherwise not legally obligated to pay.**

GUARANTOR OF PAYMENT SIGNATURE DATE: _____ TIME: _____

PRINTED NAME

EXHIBIT A

Independent Contractors at UNC Health Care Affiliates

UNC Hospitals (“UNCH”)

I am aware that physicians, nurse practitioners and physician assistants who provide services to UNCH patients may be independent contractors who provide services to UNC Hospitals’ patients in accordance with their professional judgment. These practitioners are not employees or agents of UNC Hospitals.

Rex Hospital, Inc. (“Rex”)

I am aware that the emergency room physicians, anesthesiologists, CRNAs, pathologists, psychiatrists, OB hospitalists; radiologists, and radiation oncologists, and their nurse practitioners and physician assistants, are independent contractors who provide services to Rex patients in accordance with their professional judgment. These practitioners are not employees or agents of Rex.

Caldwell Memorial Hospital, Incorporated (“Caldwell”)

I am aware that some providers, including but not limited to emergency room physicians, anesthesiologists, pathologists, radiologists, and medical and radiation oncologists, and their nurse practitioners and physician assistants, are independent contractors who provide services to Caldwell patients in accordance with their professional judgment. These practitioners are not employees or agents of Caldwell.

Chatham Hospital, Inc. (“Chatham”)

I am aware that the emergency room physicians, anesthesiologists, CRNAs, hospitalists, pathologists, and radiologists, and their nurse practitioners and physician assistants, are independent contractors who provide services to Chatham patients in accordance with their professional judgment. These practitioners are not employees or agents of Chatham.

Henderson County Hospital Corporation d/b/a Margaret R. Pardee Memorial Hospital (“Pardee”)

I am aware that the radiologists, anesthesiologist group, radiation oncologists, and pathologists, and their nurse practitioners and physician assistants, are independent contractors who provide services to Pardee patients in accordance with their professional judgment. These practitioners are not employees or agents of Pardee.

Johnston Health Services Corporation (“Johnston”)

I am aware that most physicians providing care at Johnston, and their nurse practitioners and physician assistants, are independent contractors who provide services to Johnston in accordance with their professional judgment. These practitioners are not employees or agents of Johnston.

Nash Hospitals, Inc. (“Nash”)

I am aware that all the physicians who practice at Nash and may treat me, including but not limited to emergency room physicians, anesthesiologists, pathologists, radiologists, medical and radiation oncologists, EKG readers, hospitalists (including primary care hospitalists, pediatric hospitalists, neonatologists and surgicalists), bariatric surgeons, cardiologists, psychiatrists, wound care physicians, and their respective nurse practitioners and physician assistants, are independent contractors who provide services to Nash patients in accordance with their professional judgment; and I understand that these practitioners are not employees or agents of Nash, and that Nash is not liable for their actions.

Wayne Memorial Hospital, Inc. d/b/a Wayne UNC Health Care (“Wayne”)

I am aware that the radiologists, pathologists, anesthesiologists, emergency room physicians, surgeons, psychiatrists, internists, nephrologists, oncologists, EKG readers, cardiologists, wound care physicians, intensivists, hospitalists and any other independent physician and their nurse practitioners and physician assistants, are independent contractors who provide services to Wayne’s patients in accordance with their professional judgment. These practitioners are not employees or agents of Wayne.

Wayne MRI, LLC (“Wayne MRI”)

I am aware that the radiologists at Wayne MRI are independent contractors who provide services to Wayne MRI in accordance with their professional judgment. These practitioners are not employees or agents of Wayne MRI.

UNC Rockingham Health Care, Inc. (“Rockingham”)

I am aware that some providers, including but not limited to emergency room physicians, anesthesiologists, pathologists, radiologists, and medical and radiation oncologists, and their nurse practitioners and physician assistants, are independent contractors who provide services to Rockingham patients in accordance with their professional judgment. These practitioners are not employees or agents of Rockingham.

EXHIBIT B**NOTICE OF NONDISCRIMINATION**

UNC Health Care and its affiliated Network Entities comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. UNC Health Care and its affiliated Network Entities do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

A. Free Aids and Services

UNC Health Care and its affiliated Network Entities:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need to receive these services, contact the individual identified below (Section C), for the Network Entity location where you are receiving services.

B. Grievances

If you believe that UNC Health Care or an affiliated Network Entity has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the following individuals (Section C), depending on where you are receiving services. You can file a grievance in person or by mail, fax, or e-mail. If you need help filing a grievance, the individual identified below, for the Network Entity location where you are receiving services, is available to help you.

C. Contacts

Network Entity	Person to Assist with Free Aids and Services	Person to Assist with Grievances
UNC Medical Center (UNC Hospitals; UNC Faculty Physicians; UNC Health Care Shared Services Pharmacy; UNC Homecare; and UNC Home Health)	Director of Patient Relations 101 Manning Drive Chapel Hill, NC 27514 Phone: (984) 974-5006 E-mail: patrel1@unchealth.unc.edu	Director of Patient Relations 101 Manning Drive Chapel Hill, NC 27514 Phone: (984) 974-5006 E-mail: patrel1@unchealth.unc.edu
Caldwell Memorial Hospital, Inc.	Patient Care Coordinator 321 Mulberry Street SW P.O. Box 1890 Lenoir, NC 28645 Phone: (828) 757-5100	Risk & Regulatory Department 321 Mulberry Street SW P.O. Box 1890 Lenoir, NC 28645 Phone: (828) 757-5555 E-mail: RiskMgtUNCCaldwell@unchealth.unc.edu
Chatham Hospital, Inc. and Chatham Imaging Services of Pittsboro, LLC	Interpreting Services Director 475 Progress Boulevard Siler City, NC 27344 Phone: (919) 799-4770	Director of Quality and Risk Management 475 Progress Boulevard Siler City, NC 27344 Phone: (919) 799-4015
Johnston Health Services Corp. (d/b/a Johnston Health)	Telephone Operator 509 N. Bright Leaf Boulevard P.O. Box 1376 Smithfield NC 27577 Phone: (919) 934-8171	Compliance Director 509 N. Bright Leaf Boulevard P.O. Box 1376 Smithfield NC 27577 Phone: 919-938-7121
Henderson County Hospital Corp. (d/b/a Margaret R. Pardee Memorial Hospital)	Interpreter Services 800 North Justice Street Hendersonville, NC 28791 Phone: (828) 696-4644	Civil Rights Coordinator 800 North Justice Street Hendersonville, NC 28791 Phone: (828) 698-7998
Nash Health Care Systems (Nash Hospitals, Inc.; Nash MSO, Inc.; and NHCS Physicians, Inc.)	Community Outreach/Emergency Management Coordinator 2460 Curtis Ellis Drive Rocky Mount, NC 27804 Phone: (252) 962-3461	Coordinator for Quality Support Services & Risk Management 2460 Curtis Ellis Drive Rocky Mount, NC 27804 Phone: (252) 962-8767
UNC REX Healthcare (Rex Hospital, Inc.; Rex Surgery Center of Wakefield, LLC; Rex Surgery Center of Cary, LLC; Rex Wakefield Wellness, LLC; and Rex Radiation Oncology, LLC)	Director of Patient Relations 101 Manning Drive Chapel Hill, NC 27514 Phone: (984) 974-5006 E-mail: patrel1@unchealth.unc.edu	Director of Quality Programs 4420 Lake Boone Trail Raleigh, NC 27607 Phone: (919) 784-3429
UNC Rockingham Health Care, Inc.	Administrative Supervisor 117 East Kings Highway Eden, NC 27288 Phone: (336) 520-7592 ext. 1712229	Director of Quality and Risk Management 117 East Kings Highway Eden, NC 27288 Phone: (336) 627-4212

UNC Physicians Network, LLC; and UNC Physicians Network Group Practices, LLC	Director of Patient Relations 101 Manning Drive Chapel Hill, NC 27514 Phone: (984) 974-5006 E-mail: patrel1@unchealth.unc.edu	Human Resources Executive 2000 Perimeter Park Drive Suite 200 Morrisville, NC 27560 Phone: (984) 215-4032 E-mail: contactuncpn@unchealth.unc.edu
Wayne Memorial Hospital, Inc. (d/b/a Wayne UNC Health Care) (Wayne MRI, LLC)	Patient Care Coordination Department 2700 Wayne Memorial Drive Goldsboro, NC 27530 Phone: (919) 731-6407	Patient Experience Department 2700 Wayne Memorial Drive Goldsboro, NC 27530 Phone: (919) 587-2273 Email: patient.experience@waynehealth.org

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; 1-800-368-1019; 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

D. Attention

- **ATENCIÓN:** si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al:
- **ATTENTION:** Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le:
- **CHÚ Ý:** Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số:
- **注意:** 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電:
- **ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer:
- **주의:** 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 연락처:
- **ध्यान दें:** यदि आप हिंदी बोलते हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। इस पर कॉल करें:
- **PAUNAWA:** Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa:
- **LUS CEEV:** Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau:
- **સુચના:** જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો:
- **ВНИМАНИЕ:** Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните:
- **Dè dè nà kè dyédéé gbo:** Ɔ jǔ kɛ̀ n̄ [Bàsɔ̀wò-wùdù-pò-nyò] jǔ ní, níí, à wuɖu kà kò d̀ò pò-pò̀ b̄éin n̄ gbo kpáa. Ðá:
- **గమనిక:** మీరు తెలుగు భాషను మాట్లాడేవారు అయితే, భాష సహాయక సేవలు మీకు ఎటువంటి ఛార్జీలు లేకుండా ఉచితంగా అందుబాటులో ఉన్నాయి. ఈ నంబర్కు కాల్ చేయండి:
- **ATTENZIONE:** In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero:
- **ملحوظة:** إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم

UNC Medical Center (UNC Hospitals, UNC Faculty Physicians, UNC Shared Services Center Pharmacy, UNC Homecare, and UNC Home Health):

1-984-974-5006

Caldwell Memorial Hospital:

1-828-757-5100

Chatham Hospital and Chatham Imaging Services of Pittsboro:

1-984-974-5006

UNC REX Healthcare (Rex Hospital; Rex Surgery Center of Wakefield; Rex Surgery Center of Cary; Rex Wakefield Wellness; and Rex Radiation Oncology):

1-984-974-5006

Johnston Health:

1-919-934-8171

Margaret R. Pardee Memorial Hospital:

1-828-696-4644

Nash Health Care Systems (Nash Hospitals, Nash MSO, and NHCS Physicians):

1-252-962-8000

UNC Rockingham Health Care

1-336-520-7592 ext. 1712229

Wayne Memorial Hospital (Wayne MRI, LLC)

1-919-736-1110

UNC Physicians Network (UNCPN) and UNC Physicians Network Group Practices (UNCPN GP):

1-984-974-5006



Patient Label Here

PSYCHIATRY GENERAL CONSENT FOR TREATMENT (PAGE 1 OF 6)

HIM# 741s

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Consent for Use and Release of Information

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For more detailed information about the way my information may be used or released, I can read UNC Health Care’s *Notice of Privacy Practices*.

I give permission to UNC Health Care affiliates and their employees, agents, and contractors to take photographs or make videos or drawings of me for permissible treatment, payment, or health care operations purposes (which may include quality assessment, education, and training), as long as consistent with policies and laws that protect my rights.

Consent for Use Within UNC Health Care

I further give permission to UNC Health Care 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, 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 Care affiliate, I agree that the overpayment may be applied to pay any outstanding charges on any of my accounts with other UNC Health Care affiliates.

I further authorize release of financial information and activity related to payment for services to:

Name of Individual: _____

Relationship to Patient: _____

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 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 Care affiliate on my behalf. I authorize UNC Health Care 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 Care affiliate.

Social Security Number

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

Wireless Telephone Number

UNC Health Care affiliates, or their agents or representatives, may contact me by telephone at any number contained in my UNC Health Care affiliate's records, including wireless telephone numbers, for the purpose of communicating with me about my health care, servicing my account and collecting amounts due. 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 this consent at any time by calling or writing to UNC Health Care.

Personal Property

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

Insurance Billing for Psychiatric Services

We will bill your insurance company for services provided to you unless you check "no" below and agree to be personally responsible for payment of all claims related to your psychiatric care. Do you want claims and related health information submitted to your health insurance carrier?

_____ (initial) **NO, I do not want** claims or related health information submitted to my health insurance carrier, and I agree that I am personally responsible for payment of all claims related to psychiatric services provided.

Increased Confidentiality for Psychiatric Services

State and federal laws require increased confidentiality for mental health, developmental disability, and substance abuse services. **Unless required by law, UNC Health Care will not release any information to people inquiring about me and the mental health and substance abuse services I receive without my consent (see specific options below).**

Patient List

As a convenience to patients and visitors, UNC Health Care keeps a list of patients currently receiving services so that we may provide the location of the patient in the facility and the patient's general condition to people who ask for patients by name.

_____ (initial) **YES, I want** to release my information in the UNC Health Care patient list.

Religious Information

UNC Health Care may provide a patient list for community clergy when they request it. This list includes the name and location of the patient, the patient's general condition, and the patient's religious affiliation.

_____ (initial) **YES, I want** to be included in UNC Health Care list provided for clergy.

Sharing Information with Family and/or Friends

As a courtesy, limited health information may be shared with family and friends under the following conditions: (1) the information is related that individual's involvement in the patient's care or payment for care, or (2) the information is needed to notify individuals responsible for the patient's care about the patient's location, general condition or death.

_____ (initial) **YES, I want** personal health information shared with family and friends.

Disclosure of Records for Civil Commitment Proceedings

If I am receiving mental health and/or substance abuse treatment under a civil commitment proceeding, UNC Health Care System may be asked to disclose my results of examinations by physicians and records - including but not limited to mental health and substance abuse treatment records - to my appointed legal counsel Dolly Whiteside, the Supervising Attorney for Office of Special Counsel of the North Carolina Indigent Defense Services, or to her designee. This disclosure would be solely for the purpose of representing me in my civil commitment proceeding.

_____(initial) **YES, I want** my information released to Dolly Whiteside or to her designees if necessary to represent me. My consent to this disclosure is subject to revocation at any time except to the extent that UNC Health Care System has already acted in reliance on it, and if not expressly revoked will terminate upon the termination of the related civil commitment proceeding.

FOR RESIDENTIAL OR INPATIENTS ONLY

Who would you like to be notified in case of a medical emergency or transfer to another facility?

NAME: _____ **TELEPHONE NUMBER:** _____

Who would you like to be notified if a restrictive intervention, such as seclusion or restraint, is used?

NAME: _____ **TELEPHONE NUMBER:** _____

_____(initial) **I DO NOT want any information released in case of emergency, transfer, or restrictive intervention.**

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, RECEIVED 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: If I sign below as guarantor (not as the patient, or spouse of the patient, or the parent of a minor child), 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

EXHIBIT A

Independent Contractors at UNC Health Care Affiliates

UNC Hospitals (“UNCH”)

I am aware that physicians, nurse practitioners and physician assistants who provide services to UNCH patients may be independent contractors who provide services to UNC Hospitals’ patients in accordance with their professional judgment. These practitioners are not employees or agents of UNC Hospitals.

Rex Hospital, Inc. (“Rex”)

I am aware that the emergency room physicians, anesthesiologists, CRNAs, pathologists, psychiatrists, OB hospitalists, radiologists, and radiation oncologists, and their nurse practitioners and physician assistants, are independent contractors who provide services to Rex patients in accordance with their professional judgment. These practitioners are not employees or agents of Rex.

Caldwell Memorial Hospital, Incorporated (“Caldwell”)

I am aware that some providers, including but not limited to emergency room physicians, anesthesiologists, pathologist, radiologists, and medical and radiation oncologists, and their nurse practitioners and physician assistants, are independent contractors who provide services to Caldwell patients in accordance with their professional judgment. These practitioners are not employees or agents of Caldwell.

Chatham Hospital, Inc. (“Chatham”)

I am aware that the emergency room physicians, anesthesiologists, CRNAs, hospitalists, pathologists, and radiologists, and their nurse practitioners and physician assistants, are independent contractors who provide services to Chatham patients in accordance with their professional judgment. These practitioners are not employees or agents of Chatham.

Henderson County Hospital Corporation d/b/a Margaret R. Pardee Memorial Hospital (“Pardee”)

I am aware that the radiologists, anesthesiologist group, radiation oncologists, and pathologists, and their nurse practitioners and physician assistants, are independent contractors who provide services to Pardee patients in accordance with their professional judgment. These practitioners are not employees or agents of Pardee.

Johnston Health Services Corporation (“Johnston”)

I am aware that most physicians providing care at Johnston, and their nurse practitioners and physician assistants, are independent contractors who provide services to Johnston in accordance with their professional judgment. These practitioners are not employees or agents of Johnston.

Nash Hospitals, Inc. (“Nash”)

I am aware that all the physicians who practice at Nash and may treat me, including but not limited to emergency room physicians, anesthesiologists, pathologists, radiologists, medical and radiation oncologists, EKG readers, hospitalists (including primary care hospitalists, pediatric hospitalists, neonatologists and surgicalists), bariatric surgeons, cardiologists, psychiatrists, wound care physicians, and their respective nurse practitioners and physician assistants, are independent contractors who provide services to Nash patients in accordance with their professional judgment; and I understand that these practitioners are not employees or agents of Nash, and that Nash is not liable for their actions.

Wayne Memorial Hospital, Inc. d/b/a Wayne UNC Health Care (“Wayne”)

I am aware that the radiologists, pathologists, anesthesiologists, emergency room physicians, surgeons, psychiatrists, internists, nephrologists, oncologists, EKG readers, cardiologists, wound care physicians, intensivists, hospitalists and any other independent physician and their nurse practitioners and physician assistants, are independent contractors who provide services to Wayne’s patients in accordance with their professional judgment. These practitioners are not employees or agents of Wayne.

Wayne MRI, LLC (“Wayne MRI”)

I am aware that the radiologists at Wayne MRI are independent contractors who provide services to Wayne MRI in accordance with their professional judgment. These practitioners are not employees or agents of Wayne MRI.

UNC Rockingham Health Care, Inc. (“Rockingham”)

I am aware that some providers, including but not limited to emergency room physicians, anesthesiologists, pathologists, radiologists, and medical and radiation oncologists, and their nurse practitioners and physician assistants, are independent contractors who provide services to Rockingham patients in accordance with their professional judgment. These practitioners are not employees or agents of Rockingham.

EXHIBIT B

NOTICE OF NONDISCRIMINATION

UNC Health Care and its affiliated Network Entities comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. UNC Health Care and its affiliated Network Entities do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

A. Free Aids and Services

UNC Health Care and its affiliated Network Entities:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need to receive these services, contact the individual identified below (Section C), for the Network Entity location where you are receiving services.

B. Grievances

If you believe that UNC Health Care or an affiliated Network Entity has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the following individuals (Section C), depending on where you are receiving services. You can file a grievance in person or by mail, fax, or e-mail. If you need help filing a grievance, the individual identified below, for the Network Entity location where you are receiving services, is available to help you.

C. Contacts

Network Entity	Person to Assist with Free Aids and Services	Person to Assist with Grievances
UNC Medical Center (UNC Hospitals; UNC Faculty Physicians; UNC Health Care Shared Services Pharmacy; UNC Homecare; and UNC Home Health)	Director of Patient Relations 101 Manning Drive Chapel Hill, NC 27514 Phone: (984) 974-5006 E-mail: patrel1@unchealth.unc.edu	Director of Patient Relations 101 Manning Drive Chapel Hill, NC 27514 Phone: (984) 974-5006 E-mail: patrel1@unchealth.unc.edu
Caldwell Memorial Hospital, Inc.	Patient Care Coordinator 321 Mulberry Street SW P.O. Box 1890 Lenoir, NC 28645 Phone: (828) 757-5100	Risk & Regulatory Department 321 Mulberry Street SW P.O. Box 1890 Lenoir, NC 28645 Phone: (828) 757-5555 E-mail: RiskMgtUNCCaldwell@unchealth.unc.edu
Chatham Hospital, Inc. and Chatham Imaging Services of Pittsboro, LLC	Interpreting Services Director 475 Progress Boulevard Siler City, NC 27344 Phone: (919) 799-4770	Director of Quality and Risk Management 475 Progress Boulevard Siler City, NC 27344 Phone: (919) 799-4015
Johnston Health Services Corp. (d/b/a Johnston Health)	Telephone Operator 509 N. Bright Leaf Boulevard P.O. Box 1376 Smithfield NC 27577 Phone: (919) 934-8171	Compliance Director 509 N. Bright Leaf Boulevard P.O. Box 1376 Smithfield NC 27577 Phone: 919-938-7121
Henderson County Hospital Corp. (d/b/a Margaret R. Pardee Memorial Hospital)	Interpreter Services 800 North Justice Street Hendersonville, NC 28791 Phone: (828) 696-4644	Civil Rights Coordinator 800 North Justice Street Hendersonville, NC 28791 Phone: (828) 698-7998
Nash Health Care Systems (Nash Hospitals, Inc.; Nash MSO, Inc.; and NHCS Physicians, Inc.)	Community Outreach/Emergency Management Coordinator Nash Health Care Systems 2460 Curtis Ellis Drive Rocky Mount, NC 27804 Phone: (252) 962-3461 Fax: (252) 962-3347	Coordinator for Quality Support Services & Risk Management Nash Health Care Systems 2460 Curtis Ellis Drive Rocky Mount, NC 27804 Phone: (252) 962-8767 Fax: (252) 962-8855
UNC REX Healthcare (Rex Hospital, Inc.; Rex Surgery Center of Wakefield, LLC; Rex Surgery Center of Cary, LLC; Rex Wakefield Wellness, LLC; and Rex Radiation Oncology, LLC)	Director of Patient Relations 101 Manning Drive Chapel Hill, NC 27514 Phone: (984) 974-5006 E-mail: patrel1@unchealth.unc.edu	Director of Quality Programs 4420 Lake Boone Trail Raleigh, NC 27607 Phone: (919) 784-3429
UNC Rockingham Health Care, Inc.	Administrative Supervisor 117 East Kings Highway Eden, NC 27288 Phone: (336) 520-7592 ext. 1712229	Director of Quality and Risk Management 117 East Kings Highway Eden, NC 27288 Phone: (336) 627-4212

UNC Physicians Network, LLC; and UNC Physicians Network Group Practices, LLC	Director of Patient Relations 101 Manning Drive Chapel Hill, NC 27514 Phone: (984) 974-5006 E-mail: patrell1@unchealth.unc.edu	Human Resources Executive 2000 Perimeter Park Drive Suite 200 Morrisville, NC 27560 Phone: (984) 215-4032 E-mail: contactuncpn@unchealth.unc.edu
Wayne Memorial Hospital, Inc. (d/b/a Wayne UNC Health Care) (Wayne MRI, LLC)	Patient Care Coordination Department 2700 Wayne Memorial Drive Goldsboro, NC 27530 Phone: (919) 731-6407	Patient Experience Department 2700 Wayne Memorial Drive Goldsboro, NC 27530 Phone: (919) 587-2273 Email: patient.experience@waynehealth.org

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; 1-800-368-1019; 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

D. Attention

- **ATENCIÓN:** si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al:
- **ATTENTION:** Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le:
- **CHÚ Ý:** Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số:
- **注意:** 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電:
- **ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer:
- **주의:** 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 연락처:
- **ध्यान दें:** यदि आप हिंदी बोलते हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। इस पर कॉल करें:
- **PAUNAWA:** Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa:
- **LUS CEEV:** Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau:
- **સુચના:** જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો:
- **ВНИМАНИЕ:** Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните:
- **Dè dè nà kè dyé dè gbo:** Ɔ jũ ké m̄ [Bàsɔ̀-wùdù-po-nyɔ̀] jũ ní, níí, à wuɖu kà kò d̀ò po-pòò b̄éin m̄ gbo kpáa. D́á:
- **ಗಮನಿಕ:** ಮಿರು ತೆಲುಗು ಭಾಷನು ಮಾಳ್ವಾಡೆವಾರು ಅಯಿತೆ, ಭಾಷ ಸಹಾಯಕ ಸೆವಲು ಮಿರು ಎಟುವಂಟಿ ಧಾಣ್ಣಿಲು ಲೆಕುಂಡಾ ಒಡಿತಿಂಗಾ ಅಂದುಬಾಟುಲೆ ಒನ್ನಾಯಿ. ಈ ನಂಬರ್‌ಕು ಕಾಲ್‌ ಚೆಯಂಡೆ:
- **ATTENZIONE:** In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero:
- **ملحوظة:** إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم:

UNC Medical Center (UNC Hospitals, UNC Faculty Physicians, UNC Shared Services Center Pharmacy, UNC Homecare, and UNC Home Health): 1-984-974-5006	Caldwell Memorial Hospital: 1-828-757-5100	Chatham Hospital and Chatham Imaging Services of Pittsboro: 1-984-974-5006	UNC REX Healthcare (Rex Hospital; Rex Surgery Center of Wakefield; Rex Surgery Center of Cary; Rex Wakefield Wellness; and Rex Radiation Oncology): 1-984-974-5006
Johnston Health: 1-919-934-8171	Margaret R. Pardee Memorial Hospital: 1-828-696-4644	Nash Health Care Systems (Nash Hospitals, Nash MSO, and NHCS Physicians): 1-252-962-8000	UNC Physicians Network (UNCPN) and UNC Physicians Network Group Practices (UNCPN GP): 1-984-974-5006
Wayne Memorial Hospital (Wayne MRI, LLC) 1-919-736-1110			UNC Rockingham Health Care 1-336-520-7592 ext. 1712229

North Carolina Surgery Medical Weight Loss Questionnaire

Today's Date:	
Name:	DOB:
Referring Physician:	Office Phone Number:
Primary Care Physician:	Office Phone Number:
Decision Maker in the Event of an Emergency:	
Decision Maker's Phone Number:	

What is your main reason for seeking obesity treatment? Circle ONE that applies:

I want this for myself ("self-motivation").

A family member insisted that I lose weight.

My physician has recommended weight loss.

Other _____

What is your main motivation for obesity treatment? Circle ONE that applies:

I would like to improve my appearance.

I would like to be more active and have a better quality of life.

I would like to improve my health conditions.

Other _____

What treatments are you interested in pursuing? Circle ALL that apply.

Lifestyle changes

Weight loss Medications

Weight loss Surgery

Goal Weight? _____

Have you had weight loss surgery previously? Yes / No

If yes, please answer the following questions, if not please move to the “Weight History” section:

Type of surgery:

Surgeon name:

Hospital name:

Date of procedure:

Weight prior to operation:

Lowest weight achieved after operation:

Are you taking vitamins and supplements as recommended: Yes / No

Weight History:

Highest adult weight _____ lbs.

Lowest adult weight _____ lbs.

Dieting History:

What diets have worked for you in the past? Please list all that apply.

What is the most weight that you have lost _____ lbs.

How long did you maintain your weight loss? _____

Are you currently working with a Registered Dietitian? Yes / No.

Have you ever been diagnosed and/or treated for an eating disorder in the past? If so, please explain:

What dietary challenges are you currently facing? (Check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Caffeine | <input type="checkbox"/> “white foods” (pasta, rice, white bread) |
| <input type="checkbox"/> Fast food | <input type="checkbox"/> Desert/sweets/candy |
| <input type="checkbox"/> Soft drinks/sugary drinks | <input type="checkbox"/> Salty foods |
| <input type="checkbox"/> Chip/carb snacks | <input type="checkbox"/> Processed foods |
| <input type="checkbox"/> Fried/fatty foods | |

What behavioral challenges are you currently facing? (Check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Eating quickly | <input type="checkbox"/> Family issues |
| <input type="checkbox"/> Binge eating | <input type="checkbox"/> Skipping meals |
| <input type="checkbox"/> Lack of motivation | <input type="checkbox"/> Food addiction |
| <input type="checkbox"/> Boredom eating | <input type="checkbox"/> Work issues |
| <input type="checkbox"/> Grazing | <input type="checkbox"/> Eating large portions |
| <input type="checkbox"/> Physical limitations | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Emotional/stress eating | <input type="checkbox"/> Depression/anxiety |
| <input type="checkbox"/> Eating out often | |

How many meals do you eat out per week?

Breakfast: _____	Fast food	Café	Cafeteria	Restaurant
Lunch: _____	Fast food	Café	Cafeteria	Restaurant
Dinner: _____	Fast food	Café	Cafeteria	Restaurant

Do you skip any meals?

Breakfast	How many days per week? _____
Lunch	How many days per week? _____
Dinner	How many days per week? _____

Which sources of protein do you eat most often?

- Red meat (beef and pork)
- Fish and Chicken
- Eggs and Dairy
- Tofu, beans, and lentils

How your proteins are normally prepared? (choose all that apply)

- Grilled
- Sautéed with butter/oils
- Baked/roasted
- Fried

How many servings of fruit do you consume each day? _____

How many servings of vegetables do you consume each day? _____

- Prepared with cheese, butter, or dressing
- Canned
- Fresh
- Frozen

Exercise: What type, how often, how long (please circle):

Frequency: 2x/wk 3x/wk 4x/wk 5x/wk more

Time per session: 30 min 45 min 1hour >1hour

Are you doing cardio? Yes No

Elliptical	Aerobics/Zumba	Treadmill	Walking
Swimming	Stationary Bike	Cycling	

Other: _____

Are you doing strength training? Yes No

Weight lifting	Strength classes	Pilates	Yoga
----------------	------------------	---------	------

Resistance Band Other: _____

Sleep:

Have you ever had a sleep study? _____

I go to sleep at _____ am/pm

I wake up at _____ am/pm.

I wake up _____ times a night because _____

Do you snore loudly? _____

Has anyone ever told you that you stop breathing while you sleep? _____

Do you feel tired, sleepy, or fatigued during the daytime? _____

Stress:

What was your stress level during the past month on a scale of 1 to 10, With 10 being the highest stress level _____?

How does stress affect you on a day-to-day basis?

What is the main cause of your stress? _____

Have you ever used any of the following medications?

Phentermine (Adipex-P)	Yes / No / I don't know
Metformin (Glucophage)	Yes / No / I don't know
Topiramate (Topamax)	Yes / No / I don't know
Bupropion (Wellbutrin)	Yes / No / I don't know
Lorcaserin (Belviq)	Yes / No / I don't know
Orlistat (Alli/ Xenical)	Yes / No / I don't know
Qsymia	Yes / No / I don't know
Contrave	Yes / No / I don't know
Saxenda/ Victoza	Yes / No / I don't know
Invokana/ Farxiga/ Jardiance	Yes / No / I don't know

Social History: Please mark all that apply.

Current Nicotine Use (including Vaping & Dipping)	Type of Nicotine?	How much per day?
Previous Nicotine Use	Type of Nicotine?	Quit Date?
Current Alcohol Use	How Often?	How Much?
Current Drug Use (including CBD products, marijuana, ect.)	Type of Drug?	How Often?

Allergies: Please list all allergies and reactions.

Allergy	Reaction

Pharmacy:

Pharmacy Name	Pharmacy Address

Current Medications:

Medication	Dose of Medication	Amount You Take Daily
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Medical History: Please mark all that apply.

Acid Reflux/Heart Burn	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	Gallstones	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	Gout	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>
Bipolar Disorder	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>
CHF	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>
Chronic Constipation	<input type="checkbox"/>	Hypothyroidism	<input type="checkbox"/>
Chronic Diarrhea	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>
Cirrhosis	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>
COPD	<input type="checkbox"/>	Pancreatitis	<input type="checkbox"/>
Depression	<input type="checkbox"/>	Pseudotumor Cerebri	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>
Diverticulitis	<input type="checkbox"/>	Stroke	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Other:	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	Other:	<input type="checkbox"/>

Surgical History: Please mark all that apply.

Appendectomy		Hysterectomy	
Bariatric Surgery		Joint Replacement	
Brain Surgery		Open Heart Surgery	
Breast Surgery		Pacemaker	
Colon Surgery		Prostate surgery	
C-section		Small Intestine Surgery	
Cosmetic Surgery		Spine Surgery	
Defibrillator		Stent Placement	
Eye Surgery		Valve Replacement	
Fracture Repair		Vasectomy	
Gallbladder Surgery		Other:	
Hernia Surgery		Other:	

Domestic Abuse:

1. Is abuse, violence, or sexual assault a problem for you in any way? Yes No
2. Does your partner/caregiver threaten you in any way? Yes No

Family History:

Relationship	Alive/Deceased	Birth Defects	Breast Cancer	Clotting Disorder	COPD	Heart Disease	Hypertension	Kidney Disease	Diabetes
Mother									
Father									
Sister									
Brother									
Daughter									
Son									

System Review: In the past month, have you had any of the following problems?

General		Urinary System		Eyes		Stomach and Intestines	
Recent weight gain		Frequent or painful urination		Pain		Nausea	
Recent weight loss		Blood in urine		Redness		Heartburn	
Fatigue				Loss of vision		Stomach pain	
Weakness		Muscle/Joints/Bones		Double or blurred vision		Vomiting	
Fever		Numbness		Dryness		Yellow Jaundice	
Night sweats		Joint Pain				Increasing constipation	
		Muscle weakness		Throat		Persistent Diarrhea	
Nervous System		Joint swelling		Frequent sore throats		Blood in stools	
Headaches				Hoarseness		Black stools	
Dizziness		Ears		Difficulty in swallowing			
Fainting		Ringling in ears		Pain in jaw		Blood	
Numbness or tingling		Loss of hearing				Anemia	
Memory loss						Clots	

System Review Continued...

Heart and Lungs		Skin	
Chest pain		Redness	
Palpitations		Rash	
Fainting		Nodules/bumps	
Swollen legs or feet		Hair loss	
Cough		Color changes of hands and feet	

Sleep Apnea Treatment:

1. Are you currently using a dental device for snoring or sleep apnea?
 - a. Type of device _____
2. Have you ever worn a dental device for snoring or sleep apnea?
 - a. Type of device _____
3. Are you currently using CPAP/bi-level therapy? Yes No
 - a. When did you start using CPAP/Bi-level therapy? _____
4. Have you ever been placed on CPAP/Bi-level therapy? Yes No
5. Have you ever had surgery for snoring or sleep apnea? Yes No

Mental Health History: Please mark all that apply.

Have you ever been diagnosed with any of the following?

Alcoholism	
Anxiety	
Bipolar Disorder	
Depression	
Obsessive Compulsive Disorder	
PTSD	
Schizophrenia	
Other:	

1. Have you ever been hospitalized for a psychiatric condition?
 - a. If so when? _____
 - b. Reason? _____
 - c. Where? _____
2. Are you currently receiving treatment by a psychiatrist for medication management?
 - a. Name of Psychiatrist _____
3. Are you currently receiving counseling from a psychologist?
 - a. Name of Psychologist? _____
4. Over the last 2 weeks, how often have you been bothered by the following problems?

0 = not at all
 1= Several days
 2= More than half the days
 3= Nearly every day

1. Little interest of pleasure in doing things _____
 2. Feeling down, depressed, or hopeless _____
 3. Trouble falling or staying asleep or sleeping too much _____
 4. Feeling tired or having little energy _____
 5. Poor appetite or overeating _____
 6. Feeling bad about yourself, or that you are a failure,
 or have let yourself or family down _____
 7. Moving or speaking slowly where other people have
 noticed. Or the opposite being so fidgety or restless
 that you have been moving around a lot more than
 usual _____
 8. Thoughts that you would be better off dead, or of
 hurting yourself _____
- Total Score:** _____

9. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
- Not difficult at all
 - Somewhat difficult
 - Very difficult
 - Extremely difficult

24 Hour Diet Recall

Please list everything that you have had to eat and drink over the past 24 hours
