REX SURGICAL SPECIALISTS

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 ____ Social Security #(some insurance 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 _____

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_____

REX
UNC HEALTH CARE

Rex Surgical Specialists

Date: _____

Authorization for Release of Patient Information

Name of Patient: _____ DOB: _____

Rex Surgical Specialists is authorized to release protected health information pertaining to the above named patient to the entities below.

Entity to Receive Information (*Initial each that is subject to this information*)

____ Leave information on voice mail ____ Give information to spouse
____ Give information to the following persons: _____ _____
Relationship

____ Employer FMLA/Disability Insurance

Description of Information to be Released (*Initial each that is appropriate*)

_____ Financial Information
_____ Results from tests and/or x-rays
_____ Family Billing Information
_____ Disability Insurance/ FMLA Forms/Medical Insurance
_____ Medical Information as follows: _____
_____ Other information as described: _____
_____ I **do not** authorize the release of any information at this time

Rights of the Patient
I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected information to be disclosed as described in this document by sending a written notification. I understand that a revocation is not effective in cases where I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal and State Law.
I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.
This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

_____ _____
Signature of Patient or Personal Representative Date

UNC HEALTH CARE

Patient Label Here

GENERAL CONSENT FOR TREATMENT (Page 1 of 4)
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.; High Point Regional Health; Regional Physicians, LLC; Premier Surgery Center, LLC; 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 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 it is signed 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 the 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.

I further authorize release of financial information and activity related to payment for services to:
Name of Individual: _____
Relationship to Patient: _____

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.

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 servicing my account and collecting amounts due. Methods of contact may include pre-recorded or artificial voice messages and the use of automatic dialing services.

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.

Patient List

As a convenience to patients and visitors, UNC Health Care affiliates may keep a list of patients currently receiving services at its facility 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. 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, friends and authorized representatives 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, friends and authorized representatives under the conditions mentioned above.

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

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, neonatologists, pathologists, psychiatrists, 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.

High Point Regional Health ("High Point Regional")

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

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 emergency department physicians, 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 the physicians, including but not limited to emergency room physicians, anesthesiologists, CRNAs, pathologists, radiologists, medical and radiation oncologists, and their 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.

Premier Surgery Center, LLC ("Premier")

I am aware that the providers at Premier are independent contractors who provide services to Premier patients in accordance with their professional judgment; and I understand that these practitioners are not employees or agents of Premier, and that Premier is not liable for their actions.

Rex Breast Care Specialists

NAME _____ **DOB** _____

Today's Date _____ **Reason for Visit** _____

ALLERGIES:

_____ _____

_____ _____

_____ _____

_____ _____

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

Name	Dose	Name	Dose

PHARMACY:

Name: _____ Address: _____

MEDICAL HISTORY:

Heart Attack	☐	High Blood Pressure	☐	Kidney Disease	☐
Heart Stent	☐	High Cholesterol	☐	Seizures	☐
Congestive Heart Failure	☐	Diabetes	☐	Thyroid Disease	☐
Defibrillator	☐	Stroke	☐	Asthma	☐
Pacemaker	☐	HIV	☐	COPD	☐
Hepatitis	☐	Cirrhosis	☐	Clotting Disorder	☐

Other (please list):

CANCER HISTORY: Please list details of any prior cancer treatments you have received

Name: _____ DOB: _____

SURGICAL HISTORY: *Please list procedure and approximate date*

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

FAMILY HISTORY:

Relation	Cancer (Y/N, site)	Clotting Disorder	Heart Disease	Other
Mother				
Father				
Sister				
Brother				
Grandmother				
Aunt				
Other (specify)				

SOCIAL HISTORY

Tobacco Use No ___ Yes ___ Former ____
Alcohol Use No ___ Yes ___ Former ____
Drug Use No ___ Yes ___ Former ____

DOMESTIC ABUSE

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

Please indicate if you have had the following symptoms *recently*:

Y	N	Rash
Y	N	Visual disturbance
Y	N	Shortness of breath
Y	N	Wheezing
Y	N	Palpitations
Y	N	Joint aches
Y	N	Seizures
Y	N	Abdominal pain
Y	N	Other (Please list below)

Y	N	Sinus Pressure
Y	N	Unexpected weight change
Y	N	Easy bruising/bleeding
Y	N	Sleep apnea
Y	N	Chest pain
Y	N	Vaginal bleeding
Y	N	Headaches
Y	N	Nervous/anxious

REX BREAST CARE SPECIALISTS

THE FOLLOWING INFORMATION IS IMPORTANT TO YOUR BREAST EXAM

PLEASE ANSWER ALL QUESTIONS

YES **NO**

___ ___ Do you have a breast lump?
Which breast?_____
Who discovered the lump? Doctor Myself Spouse

___ ___ Do you have nipple discharge?
If yes, circle one: Bloody Clear Milky Other_____

___ ___ Do you have skin dimpling (puckering)?

___ ___ Have you ever had a mammogram or breast ultrasound?
If yes, where? _____
Date of most recent:_____

___ ___ Do you have an abnormal mammogram?

___ ___ Have you been pregnant?
How many times have you been pregnant? _____
How many live births have you had? _____
How old were you when your first child was born? _____
Did you breast feed your children? _____

___ ___ Have you had any previous breast surgery?
If yes, which breast? _____
What kind of surgery was performed? _____
When was the surgery? _____
Circle the reason for the breast surgery:
Cancer Cysts Fibrocystic Solid tumor (not cancer) Other_____

___ ___ Have you had a hysterectomy?
If yes, when?_____
Circle the reason for hysterectomy: Bleeding Tumors Cancer Other_____

___ ___ Have your ovaries been removed?

___ ___ Have you ever taken hormone replacement therapy?
If yes, please list: _____
When and for how long? _____

___ ___ Have you ever taken birth control pills?
If yes, please list:_____
When and for how long?_____

___ ___ Has any female in your family had breast or ovarian cancer?
If yes, who?_____
Is the person above from your mother's or father's family? _____

___ ___ Has any male in your family had prostate cancer?
If yes, who?_____

How old were you when you started having your period?_____

When was your last period?_____