



# PIEDMONT

Health Services, Inc.  
"People Caring For People"



## Business Health Services Registration Form (Please Print)

Name: \_\_\_\_\_

Responsible Party: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
(If under 18)

Number of Dependents: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Best Phone number to reach you: (\_\_\_\_) \_\_\_\_\_ 2<sup>nd</sup> Phone: (\_\_\_\_) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: Male\_\_\_ Female\_\_\_

Race: White/Caucasian\_\_\_ Black/African American\_\_\_ Asian\_\_\_ Multi-racial\_\_\_  
American Indian\_\_\_ Other\_\_\_ Hispanic: Yes \_\_\_ No\_\_\_

Circle appropriate program name:

Associations:	Chamber of Commerces:	
Greater Chapel Hill Association of Realtors (GCHAR)	Chapel Hill- Carrboro	Caswell County
	Hillsborough-Orange County	Chatham
	Roxboro Area	

GCHAR Employer: \_\_\_\_\_

Chamber Employer: \_\_\_\_\_

Employed Since: \_\_\_\_\_

Job/Occupation: \_\_\_\_\_

Email: \_\_\_\_\_ Military Veteran: Yes\_\_\_ No\_\_\_

Piedmont Health Center where you want to receive care: \_\_\_\_\_

**Emergency Contact:** Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**\*\*\*Please bring Photo Identification upon your first arrival at one of our  
six Community Health Centers\*\*\***

### TREATMENT/OPERATION/PAYMENT AGREEMENT WITH PIEDMONT HEALTH SERVICES, INC.

I authorize PIEDMONT HEALTH SERVICES to provide me and/or my family with medical/dental care. I authorize assignments of insurance benefits for medical/dental care to be paid to PIEDMONT HEALTH SERVICES. I authorize the use or disclosure of protected health information belonging to myself and/or family members for the purposes of treatment and operations. I understand that it is my responsibility to pay for the medical/dental care provided by PIEDMONT HEALTH SERVICES. I have reviewed the Notice of Information Privacy Practices and have been offered a copy of it. I have been given an opportunity to ask questions about the Privacy Policy and the protection of my confidential health information at PIEDMONT HEALTH SERVICES.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient or responsible party if under 18)



## Notice of Information Privacy Practices

Effective date: April 13, 2003

**WE HAVE A LEGAL DUTY TO PROTECT HEALTH INFORMATION ABOUT YOU**  
This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

Piedmont Health Services may use or disclose Protected Health Information (PHI) about you in the following circumstances:

- *To provide health care treatment to you*
- *To obtain payment for services rendered*
- *For operation of our health care facilities*
- *When the state or federal law requires it*
- *To contact you with appointment reminders*
- *To contact you with information about treatment or services*

Where your Protected Health Information is concerned, you have the right

- *To object to certain uses or disclosures*
- *To request restrictions on the uses or disclosure of information about you*
- *To request different ways of communicating with you*
- *To request copies of your health care information*
- *To request an amendment of PHI about you*
- *To see a list of disclosures we have made of your PHI*
- *To request a copy of this notice*

You may file a complaint about our privacy practices.  
To do so, please ask to speak with the Center Manager.

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If you have questions about the rights and protections that guard the privacy of your health information at Piedmont Health Services, please contact:

Privacy Officer  
Piedmont Health Services, Inc.  
PO Box 17179  
Chapel Hill, NC 27519-7179  
(919) 933-8494