# SOUTH CENTRAL PRIMARY CARE CENTER, INC.
## *PATIENT INFORMATION*

**Account #:** _____ **Date:** _____

**Last Name:** _____ **First Name**: _____ **Middle Initial:** _____

**Address:** _____ **City:** _____

**State:** _____ **Zip:** _____ **SSN:** _____

**Home Phone#:** _____ **Work Phone #** _____

**Cell Phone #:** _____ **Is it OK to leave a message?** *YES ☐ NO ☐*

**Veteran:** *YES ☐ NO ☐* **Date of Birth:** _____ **Age:** _____ **Sex:** _____

**Race:** (Please check one) (Hispanics please choose white or black as your race)

☐ White ☐ Black/AA ☐ Asian ☐ American Indian/Alaskan Native ☐ Other _____

**Gender Identity:** (Please check one)

☐ **M** ☐ **F** ☐ Other ☐ Transgender Male/Female-to-Male ☐ Transgender Female/Male-to-Female

☐ Choose Not to Disclose

**Sexual Orientation:** (Please circle one)

☐ Straight ☐ Lesbian or Gay ☐ Bisexual ☐Something Else ☐Don't Know ☐ Choose Not to Disclose

**Marital Status:** _____ **Ethnicity**: Are you Hispanic or Latino? *YES* ☐ *NO* ☐

**Pharmacy**: _____ **City**: _____

### ***EMERGENCY CONTACT INFORMATION***

**Name of person in case of emergency:** _____

**Address**: _____ **City/State/Zip**: _____

**Relationship**: _____ **Phone**: _____**SSN (if applicable)**: _____

### ***PAYOR SOURCE***

☐Medicaid ☐Medicare ☐Insurance ☐Wellcare ☐Peach State ☐ Self ☐ Sliding Fee Scale

### ***EMPLOYER INFORMATION***

**Employer:** _____

**Address**:_____

**City**: _____ **State**: _____ **Zip**: _____ **Phone**: _____

INITIAL _____

**Income Levels:**

Because South Central Primary Care Center is a Federally Qualified Health Center, we are required to request certain income levels on our patients. This information is for South Central Primary Care Center, Inc. use and will not be distributed or published in any way. Please complete the following information.

What is your annual household income?

☐ $0 - $12,880
☐ $12,881 - $16,100
☐ $16,101 - $19,320
☐ $19,321 - $25,760
☐ $25,761 - $32,200
☐ $32,201 - $38,640
☐ $38,641 - $45,080
☐ $45,080 - $51,520
☐ $51,521 and above

Number of family members in household: _____

Characteristics: (Please answer the following. Please circle one.)

| | | |
|---|---|---|
| Homeless: | Y | N |
| Transitional: | Y | N |
| Street: | Y | N |

## ***AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS/PHYSICANS***

I hereby give my permission to release medical information about my health condition to the family members/physicians listed below. I understand that I have the right to revoke this authorization in writing at any time.

_____

Name Date of Birth Phone

_____ _____

Name Date of Birth Phone

## ***NOTICE OF PATIENT RESPONSIBILITY***

The staff of this office will always try their best to notify patients of test results **IF THEY ARE ABNORMAL;** however, it is our experience that patients may not be reachable and follow up may get lost. By signing this form, you understand that you are responsible for obtaining your test results from our office.

I, _____, understand that I am responsible for returning for follow-up to go over the results of x-rays or lab test. I will call the office for the results if I am not given a return appointment or if I cannot return for a scheduled appointment. I relieve South Central Primary Care Center,Inc. of the responsibility of notifying me of the results of any studies ordered. I assume the responsibility of contacting the office to get the results of any tests that are ordered.

INITIAL _____

# ***CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY***

I, authorize South Central Primary Care Center and its Affiliated Providers to view my external prescription history via the RX Hub Service.
I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions from years past.

MY APPLICATION SIGNATURE CERTIFIES THAT I HAVE READ AND UNDERSTAND THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

INITIAL _____

# ***GENERAL CONSENT FOR CARE AND TREATMENT***

***TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).***

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

☐ (Yes) ☐ (No) I consent to voluntary and confidential participation in Family Planning.

☐ (Opt in) ☐ (Opt out) I consent for South Central Primary Care Center, INC to share information with Common Well and Care Quality for the purpose of continuity of my health care needs.

☐ I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

INITIAL _____

## SIGNATURE ON FILE

**I understand that Physician Assistants (PA) and Nurse Practitioners (NP) perform services in this facility. I understand that I have the right to see the physician prior to receiving any prescription drug or device from the Physician Assistant or Nurse Practitioner.**

_____
***Printed Name***

_____ _____
***Signature*** ***Date***

# South Central Primary Care Center, Inc.
## *Insurance Consent and File*

**Patient:** _____ **Parent/Guardian:** _____

**Information:** Do you have insurance? □ Yes □ No Do you have Medicaid? □ Yes □ No

Primary Insurance carrier: _____ Policy Holder: Self □ other (answer below)

Secondary Insurance carrier: _____ Policy Holder: Self □ other (answer below)

**Policy holder's information (if other than patient):**

Name: _____ □ Jr. □ Sr.

Date of Birth: _____ / _____ / _____ Sex: □M □F Social Security # _____

Relationship to patient: _____ Employer: _____

### Release of Medical Information

I hereby authorize the physician involved with my (named patient) care to release information from my (their) medical record as may be required to any person, corporation, or agency which is legally responsible or has good cause to believe is legally responsible for processing and/or paying all or any part of the physicians charges and/or professional fees; to any entities designated by me for discharge and planning purposes.

### Medicare Consent (if applicable)

I certify that the information given by me in applying for payment under title XVIII (Medicare) of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare Claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services. The Medicare intermediary advises that the type of services may no longer qualify as covered under Medicare.

### Assignment of Benefits/Financial

I hereby assign payment directly to South Central Primary Care Center, Inc., all insurance benefit payments (including any major medical payments) due to me as a result of the named patient's outpatient treatment or service and pursuant to any insurance contract I have which provides for such treatment. I agree to be responsible for any charges incurred that are not paid by insurance or other third party payers.

**** I agree that co-insurance or deductible amounts are my responsibility. I also acknowledge that the filing of insurance claims is NOT a guarantee of payment, and that I am financially responsible for payment if such claims are unpaid. I understand there is a $30.00 fee for returned checks and all collection fees or attorney fees as a result of delinquent payment will be my responsibility. ** I** understand laboratory and/or pathology fees are associated with some procedures and agree to pay these to the appropriate facilities including outside pathology facilities.

By signing this document, I acknowledge that I have read and understand this consent. Further, I hereby consent and authorize this facility to use or disclose my Protected Health Information in conjunction with Treatment, Payment or Health Care Operations in accordance with the terms of this consent.

**Signature:** _____ **Date:**_____

**Circle: Patient Legal Guardian POA**

***Please present your insurance card(s) and your valid photo identification to the receptionist. The Receptionist will make a copy and return them to you promptly. Copays are due at check-in. Thank you.***