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

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.

Effective Date: March 23, 2013

NOTICE OF PRIVACY PRACTICES

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.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. We must obtain your authorization before the use and disclosure of any psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosure that constitute a sale of PHI. Uses and disclosures not described in this Notice of Privacy Practices will be made only with authorization from the individual.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the Center may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the Center or the hospital. For example, we may disclose medical information about you to people outside the Center who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the Center and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other Center personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts. WHO WILL FOLLOW THIS NOTICE. This notice describes our Center's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other Center personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the Center. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the Center, whether made by Center personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; and others; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny *your* request to inspect and copy in certain very limited circumstances.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the Center. To request an amendment, your request must be made in writing and submitted to the Quality Improvement Coordinator and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Quality Improvement Coordinator.

Right to Request Removal from Fundraising Communications. You have the right to opt out of receiving fundraising communications from the Center. Right to Restrict Disclosures to Health Plan. You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment of health care operations and pertains to a health care item or service for which the individual has paid out of pocket in full.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Quality Improvement Coordinator.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the Center's waiting room.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the Center or with the Secretary of the Department of Health and Human Services. To file a complaint with the Center, contact the Quality Improvement Coordinator at P.O. Box 749, Ocilla, GA 31774. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Quality Improvement Coordinator at (229) 468-9166.

I acknowledge by signing below that I have received a **Notice of Privacy Practices and Notice of Individual Rights.**

Patient/Patient Representative Signature *Date*

South Central

Primary Care Center, Inc.

"Building a Healthy Community"

The patient portal is a secure web portal that allows you as a patient to access medical records including medications, lab results, and medical history via the internet. It also allows you to request refills online. A link to our portal is available on our website, SCPCCGA.ORG.

This is not mandatory for our patients, but is an optional service that we offer. If you are interested in participating in the Portal, please read the following policy carefully and sign at the bottom of the page:

- We are offering the patient portal as a convenience to you at no cost. We do not sell or give away any private information, including email addresses, without your written consent. We reserve the right to suspend or terminate the patient portal at any time and for any reason.
- Please note that the portal is not checked or updated on weekends.
- We do not refill controlled substances over the portal.
- If you find you are not receiving emails from us, please check your JUNK email folder before contacting us.
- By using this patient portal, you agree to protect your password from any unauthorized individuals. It is your responsibility to notify us should your password be stolen. You agree to not hold South Central Primary Care Center, Inc. responsible for any network infractions beyond our control.

Your signature below confirms that you have read and fully understand our policies for on line communication and wish to participate in our patient portal.

Name _____

Email address _____

Signature _____ Date _____

South Central Primary Care Center, Inc.
P.O. Box 749
Ocilla, Ga 31774
(229) 468-9166

South Central Primary Care Center, Inc.

South Central Primary Care Center, Inc.

Patient Rights and Responsibilities

Our Practice is committed to providing quality health care. It is our pledge to provide this care with respect and dignity. In keeping with this pledge and commitment, we present the following Patient Rights and Responsibilities:

You have the right to:

- Competent, considerate and respectful health care, regardless of race, creed, age, sex or sexual orientation.
- Humane treatment in the least restrictive manner appropriate for treatment needs.
- To receive healthcare free from mental, physical and sexual abuse.
- The expectation that we will take reasonable steps to overcome cultural or other communication barriers that may exist between you and the staff. This includes receiving interpretation services when needed.
- To receive treatment from licensed medical personnel.
- An individualized treatment plan specific to your medical needs.
- A complete, easily understandable explanation of your condition, treatment and chances for recovery; as well as the freedom to ask abut diagnoses and overall prognosis. This includes information necessary to make an informed decision about any treatment or procedure, except as limited in an emergency situation.
- Participate in decisions regarding your healthcare.
- Information about the medical consequences of exercising your right to refuse treatment.
- The personal review of your own medical records by appointment and in accordance with applicable State and Federal guidelines.
- Confidential management of communication and records pertaining to your medical care.
- An explanation of your medical bill regardless of your insurance and the opportunity to personally examine your bill.
- The opportunity to file a complaint or grievance should a dispute arise regarding care, treatment or service or to select a different clinician.
- To request treatment from a different provider when other qualified providers are available.
- To receive coordination of Care between South Central Primary Care Center, as your Medical Home, and any specialist or ancillary care you receive.
- To obtain information about Advance Directives.

South Central Primary Care Center, Inc.

You are responsible for:

- Being respectful to all South Central Primary Care Center Providers and staff members, as well as other patients in the clinic.
-
- Following the office's rules about patient conduct; for example, there is no smoking in our office.
- Respecting the rights and property of our staff and other persons in the office.
- Knowing your health care clinician's name and title.
- Giving your clinician correct and complete health history information, e.g. allergies and/or sesitivities, past and present illnesses, medications and hospitalizations.
- Providing staff with correct and complete name, address, telephone and emergency contact information each time you see your clinician so we can reach you in the event of a schedule change or to give medical instructions.
- Providing staff with current and complete insurance information, including any secondary insurance, each time you see your clinician.
- Signing a "Release of Information" form when asked so your clinician can get medical records from other clinicians involved in your care.
- Telling your clinician about all prescription medication(s), alternative, i.e. herbal or other, therapies, or over-the-counter medications you take. You must bring all prescription bottles to each appointment to be reviewed with your provider.
- Telling your clinician about any changes in your condition or reactions to medications or treatment.
- Asking your clinician questions when you do not understand your illness, treatment plan or medication instructions.
- Following your clinician's advice. If you refuse treatment or refuse to follow instructions given by your health care clinician, you are responsible for any medical consequences.
- Keeping your appointments. If you must cancel your appointment, please call the health center at least 24 hours in advance.
- Paying copayments or nominal fees at the time of the visit or other bills upon receipt, unless prior arrangements have been made.
- Providing in home assistance for your care if needed, and transportation to and from medical services.

South Central Primary Care Center, Inc.
Patient Rights and Responsibilities

I have received a copy of South Central Primary Care Center's Patient rights and Responsibilities. I have reviewed these rights and responsibilities, and understand my role in my medical care and decision-making.

_____

Patient Signature Date

South Central Primary Care Center, Inc.
Payment Policy

I understand it is the policy of South Central Primary Care Center that payment is due at the time of service unless other financial arrangements are made in advance. All copays, coinsurance amounts, and nominal fees are due at the beginning of each visit unless prior arrangements have been made.

_____

Patient 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.

P.O. Box 749, Ocilla, GA 31774 **Phone: (229) 468-9166**

South Central

Primary Care Center, Inc.

"Building a Healthy Community"

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby request and authorize: **South Central Primary Care Center**
Location: _____
Fax: (229) 468-9169

To obtain from: _____
(Name of Agency holding the Protected Health Information)

_____
(Address of Agency holding the Protected Health Information)

The following information is to be disclosed:

- ☐ **Complete Medical Record**
- ☐ **Immunization Record**
- ☐ **PPD or Lead Screen**
- ☐ **Recent Lab/x-ray Reports**
- ☐ **Recent Hospital Reports**
- ☐ **Consultation Reports**
- ☐ **Health Check**
- ☐ **Last 3 Visits**
- ☐ **Discharge Summary**
- ☐ **Other** _____

For the purpose of: **Continuation of Medical Care**

I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information might be re-disclosed without obtaining my authorization.

I understand that I have the right to:

- **Receive a copy of this authorization**
- **Refuse to sign this authorization and that my treatment, payment, enrollment in a health plan, or eligibility for healthcare benefits may not be contingent on signing this authorization**
- **Revoke this authorization in writing, at any time, but if I do, it will have no effect on any actions taken before the organization received the revocation.**

(Name of Patient) **(Date of Birth)** **(Social Security Number)**

_____
(Signature of Patient or Patient Representative) **(Date)**

_____
(Printed Name or Patient's Representative) **(Date)**

_____
(Witness Signature) **(Title or Relationship)** **(Date)**

South Central Primary Care Center, Inc.
406 W 5TH ST.
OCILLA, GA 31774
PH (229) 468-9166

South Central Primary Care Center, Inc.

Release of Information

Mailing Address: P O Box 749, Ocilla, GA 31774
Fax: 229-468-9169

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

1. I hereby authorize _____ to use and/or disclose the protected health information described below to/from _____
_____

2. Authorization for Release of Information. Covering the period of health care from

□ _____ to _____ **OR** □ all past, present and future periods:

A. □ I hereby **authorize the release of my complete health record** (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse).

OR

B. □ I hereby **authorize the release of my complete health record with the exception of the following information**:

□ Mental health records
□ Communicable diseases (including HIV and AIDS)
□ Alcohol/drug abuse treatment
□ Other (please specify): _____

3. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

4. This authorization shall be in force and effective **one year**, at which time this authorization expires.

5. I understand that I have the right to revoke this authorization, in writing, at any time.

I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____ _____
Signature of Patient or Personal Representative Date of Birth Date

_____ _____
Print Name of Patient or Personal Representative Relationship to Patient