

Once you have completely filled out this form please save and email to: covid19@scpcgga.org

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 check 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 - \$12,760
- \$12,761 - \$15,950
- \$15,951 - \$19,140
- \$19,141 - \$25,520
- \$25,521 - \$31,900
- \$31,901 - \$38,280
- \$38,281 - \$44,660
- \$44,661 - \$51,040
- \$51,041 and above

Number of family members in household: _____

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

- Homeless: Y N
- Migrant Worker: Y N
- Seasonal Worker: Y N
- Transitional: Y N
- Street: Y N

AUTHORIZATION TO RELEASE
MEDICAL INFORMATION TO FAMILY MEMBERS/PHYSICIANS

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
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Name	Date of Birth	Phone
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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.