PRIMARY CARE OF SOUTHWEST GEORGIA

PATIENT INFORMATION

Patient's Name: _____ SS# _____
(Last) (First) (Middle Initial)

Date of Birth: _____ Sex: _____ Marital Status: ❑ Single ❑ Married ❑ Divorced

Address: _____

Cell Phone: (_____) _____ Home Phone: (_____) _____

Employer: _____ Work Phone Number: (_____) _____

Emergency Contact Name: _____ Emergency Phone: (_____) _____

RESPONSIBLE PARTY INFORMATION IF DIFFERENT FROM PATIENT

Last Name *First Name* *MI* *SS#*

Date of Birth: _____ Sex: _____ Marital Status: ❑ Single ❑ Married ❑ Divorced

Address: _____

Cell Phone: (_____) _____ Home Phone: (_____) _____

Employer: _____ Work Phone Number: (_____) _____

INSURANCE POLICY HOLDER INFORMATION

Primary Policy Holder _____ DOB _____ SS # _____

Employment Name & Address: _____

_____

Policy # _____ Group # _____ Effective Date _____

Secondary Policy Holder _____ DOB _____ SS # _____

Employment Name & Address: _____

_____

Policy # _____ Group # _____ Effective Date _____

******PLEASE PROVIDE ALL INSURANCE COVERAGE INFORMATION TO RECEPTIONIST AT FRONT DESK******

The above information that is provided is correct to the best of my knowledge.

_____ _____
Patient/Responsible Party's Signature Date

Patient Financial Policy

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. The **patient or responsible party** is responsible for seeing that the entire bill is paid in full.

We will ask to see your insurance card on your first visit and will copy your card for our record. WE will ask for this information on a regular basis, at least once a year, in order to ensure that no change in benefits or carrier has occurred. Please notify us if your insurance carrier or policy has changed. **Billing of insurance is a courtesy we provide for patients.**

Copayments:

Your insurance **REQUIRES** that we collect your designated co-pay at the time of service. Please be prepared to pay the co-pay at each visit.

Deductibles and Co-Insurance:

PCSG will bill your insurance company as a courtesy to you. If a coinsurance and/or deductible apply, you are financially responsible for this amount.

Self-Pay/Uninsured:

Self-accounts shall exist if a patient has no insurance coverage or no evidence of insurance coverage. For new patients, a payment is required on the day of your appointment **before** being seen by the health care provider. PCSG also offers the Sliding Fee Scale Program to assist our patients in financial need (qualification for the program is based on household income). An application is available at the front desk for those who wish to apply.

Workers' Compensation and Automobile Accidents

In the case of a workers' compensation injury or automobile accident, you must obtain the claim number, phone number, contact person, and name and address of the insurance carrier prior to your visit. If this information is not provided, you will be asked to either reschedule your appointment or pay for your visit at the time of service.

Extended Payment Arrangements

In certain circumstances, extended payment arrangements may be made with PCSG. The balance is to be paid on EVERY month until there is a $0 balance.

Divorce Cases

In cases of divorce, the parent or legal guardian bringing (a) child in for care is responsible for payment at the time of service.

Patient Portal

PCSG offers you electronic access to your health information through our secured Patient Portal. This system allows you to review your health record online and also gives you the opportunity to communicate with our office electronically to schedule an appointment, retrieve tests results, or request medication refills. This service is provided as a benefit for our patients. If you are interested in this program, please let our registration clerk now.

Patient-Centered Medical Home

We practice under the Patient-Centered Medical Home (PCMH) model of care. This program is a way of saying that you, the patient, are the most important person in the health care system. A medical home is a process specific to how comprehensive health care is delivered to individuals. The team at Primary Care of Southwest Georgia (PCSG) manages your care and services for you acting as the "hub" of your medical home. PCMH puts you, the patient, at the center of the health care system, and provides primary care that is Accessible, Continuous, Comprehensive, Community-Oriented, Coordinated and Compassionate.

Accountable Care Organization (ACO)

PCSG is a member of the Accountable Care Coalition of Georgia which is an ACO. Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients. Patients on Medicare may opt in or out of participation in an ACO. The ACO will use data from claim submissions to improve the availability of needed services for patients to improve their health status, and reduce ER visits and hospitalizations. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

Medication Assistance Programs

PCSG offers prescription assistance programs (for qualifying participants) which help with the cost of medications.

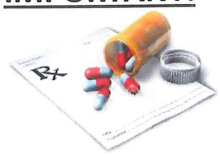
Revised: 11/08/2018

WHAT TO EXPECT FROM OUR OFFICE!

Always remember to bring in your medication(s) to each appointment.

Front Desk Staff will update personal information at each appointment.

IMPORTANT:



If you are in need of a medication refill, please call your pharmacy 2 weeks before medications are out and have them fax a medication refill request to our office. Please allow at least 72 hours to have a response answered.

PCSG also offers the Sliding Fee Scale Program to assist our patients in financial need (qualification for the program is based on household income). Applications, including instructions, are available the front desk.

PCSG works to provide our patients with timely, respectful, and considerate healthcare services. We ask that you afford our staff and providers the same courtesy. If you are unable to keep your appointment, please call our office to cancel. We can reschedule your appointment at a more convenient time for you.

Patients who fail to call to cancel or reschedule are considered no-show appointments. We value your time and ask that you value our time as well. Three consecutive no-show appointments are justification for dismissal from our practice. If you have 2 no-show appointments within 6 months, you will not be able to schedule an appointment. You will be required to walk in and wait in the lobby on a cancellation or no-show in order to be seen. Your wait time will be long and we do not guarantee you will be seen the same day.

After hours services are available by calling our clinic office number 229-227-5510, which will connect you with our answering services. The answering service will have the on-call provider contact you.

If you receive care at an emergency room or urgent care center, please let us know by calling the main office at 229-227-5510 within 48 hours so we can assist with follow-up care as needed.

Revised Date:
11/08/2018

PRIMARY CARE OF SOUTHWEST GEORGIA

Patient Acknowledgement Form
Authorization, Consent, and Disclosure

Consent for Treatment
I hereby consent to any treatments or diagnostic studies considered necessary by the Physician, Nurse Practitioner, Physician Assistant or other medical personnel of Primary Care of Southwest Georgia, Inc.

Information Release
I authorize the release of any medical information including information related to psychiatric care drug and alcohol abuse and HIV/AIDS confidential information necessary to process insurance claims or any medical information that is needed for an utilization review or quality assurance activities.

Assignment of Benefits
I assign all medical and/or surgical benefits including major medical benefits to which I am entitled to Primary Care of Southwest Georgia, Inc.'s provider and/or representative. This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original.

External Prescription History
I authorize Primary Care of Southwest Georgia, Inc. and its affiliated providers to view my external prescription history via the RxHub service.

I understand that the 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 back in time for several years.

HIE Consent & Change Form
The Primary Care of Southwest Georgia (PCSG)Health Information Exchange (HIE) grants clinicians participating in your care access to your most up to date medical records. This consent is to establish if you would like to participate in the PCSG HIE. Note: You can change your consent at any time by going to your healthcare provider and requesting a change.

I give consent to allow access to my medical records, when necessary, to participating healthcare professionals through the PCSG HIE.

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices.

Our practice will make a good faith effort to obtain written acknowledgement of receipt of the Notice of Privacy Practices provided to the individual. If written acknowledgement is not obtained, our practice must document its good faith efforts to obtain such acknowledgement and record the reason why the acknowledgement was not obtained.

Patient Responsibility

We believe that each patient has a responsibility:

1. To cooperate with the staff.
2. To provide accurate and complete health care information.
3. To indicate whether he/she understands the contemplated plan of medicine and nursing management, and the kind of compliance that is expected of him/her.
4. To keep appointments, if at all possible, or to notify the clinic if unable to do so.

Patient Rights

It is the objective of Primary Care of Southwest Georgia, Inc. and all professional and supportive personnel working in behalf of the patient to uphold rights of all patients. We believe:

1. That the individual dignity of man should be upheld at all times.
2. All patients should be provided supportive and rehabilitative care to their individual needs and environment.
3. An environment should be provided that contributes to the patient's care, safety and sense of well-being.
4. Fair and humane treatment should be provided to all patients under all circumstances, regardless of considerations of race, color, creed, or national origin, or the source of financial payment for care.
5. Each individual patient has certain rights of privacy regarding care and personal circumstances, medical information, and financial information concerning patients should be treated confidentially at all times. The patient has a right to ask questions and receive appropriate information regarding the nature and extent of his/her medical problem, the planned course of treatment, and the prognosis.
6. Each patient will be given the opportunity for informal participation in his/her health care.
7. The patient has the right to refuse treatment to the extent permitted by law, to be informed of the medical consequences of his/her actions, and to request consultation or referral.
8. The patient has the right to efficient and cost-effective care in order to hold his/her health costs to a minimum.

9. When a neonate, child, or adolescent is a patient, his/her family and/or guardian may represent the patient in securing his/her rights as a patient and shall be given the care appropriate to his/her needs.
10. Each patient has the right to present complaints concerning the quality of patient care that he/she has received.
11. Each patient has a right to a copy of his/her medical records.
12. Each patient has a right to formulate advance directives and to appoint a surrogate to make health care decisions on his/her behalf.

The above includes requisite information for services at Primary Care of Southwest Georgia, Inc. My signature acknowledges my review, understanding, and consent of all items included herein.

_____ _____

Patient/Guardian Signature Date

Primary Care of Southwest Georgia, Inc.

Permission for Release of Health Information

I_____ hereby give permission for the staff of Primary Care of Southwest GA, Inc. and my provider to give **my/my child's** health information to the person that I indicate below.

You may communicate with the following individual regarding **my/my child's** condition or course of treatment.

Name: _____
Address: _____
_____
Telephone: _____
Relationship: _____

Name: _____
Address: _____
_____
Telephone: _____
Relationship: _____

I am fully informed as to the content of this form and understand the reason for this release of information. I understand that I have a right to revoke this authorization at any time. I understand if I revoke the authorization, I must do so in writing and present my written revocation to the practice.

_____ _____
Patient/Guardian Date

Consent to Obtain External Prescription History

I, _____, whose signature appears below, authorize Primary Care of Southwest Georgia's providers and staff to view my/my child's external prescription history in the RxHub service.

I understand **my/my child's** prescription history from multiple other unaffiliated medical providers, insurance companies and pharmacy benefit managers will be viewable by Primary Care of Southwest Georgia's providers and staff, and the information may include prescriptions that have been filled over the past several years.

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

_____ _____
Patient/Guardian Date

_____ _____
Witness Date

PRIMARY CARE OF SOUTHWEST GEORGIA, INC.

INFORMED CONSENT FOR SIMPLE AND COMMON TREATMENTS & PROCEDURES

BEFORE SIGNING YOU MUST READ THIS FORM IN ITS ENTIRETY

1. I hereby grant permission to Primary Care of Southwest Georgia, Inc. (PCSG) to perform such tests, treatments and procedures as ordered by the medical staff for diagnostic and/or therapeutic purposes, including, but not limited to, STD testing including but not limited to HIV. As part of the testing and treatment I may receive disease-specific prevention, education and risk-reduction services.

2. These procedures are ordered for my benefit to improve my health and well being and/or relieve my symptoms.

3. While these types of procedures are routinely performed in the Provider Office without incident, there are certain risks associated with each of the Procedures.

4. The Provider, his/her associates or assistants and/or office staff are responsible for providing me with information about the procedures and for answering all of my questions. It is not possible to list each and every risk for every procedure used in modern healthcare. However, the physicians, physician assistants, nurse practitioners, and nurse midwives who practice medicine at Primary Care have attempted to identify the most common procedures, their risks and possible alternatives. I agree to ask my provider, his/her associates or assistants, and/or office staff to provide additional information. I further acknowledge and understand that my provider may ask me to sign a separate informed consent document (for example, a surgical procedure).

5. I understand that I always have the right to not take any medication and refuse any procedure or test even if I have previously consented to it. The alternative for not accepting the treatment prescribed and doing nothing is that my condition may get worse, stay the same, or possibly get better on its own.

   The procedures referenced herein may include, but are not limited to the following:

   A. Needle sticks, such as shots, injections or intravenous injections (IV). The risks associates with those types of procedures include, but are not limited to, nerve damage causing tingling or burning, infection swelling, bruising, infiltration (fluid leakage into surrounding tissue), skin sloughing, bleeding, clotting, allergic reactions or paralysis. Alternatives to Needle sticks (if available), include oral, rectal, nasal, or topical medications such as ointments (which may be less effective) or refusal of treatment.

   B. Physical tests and treatments such as vital signs, internal body examination, wound care, wound cleansing, wound dressing, suturing of wounds, minor surgeries to excise skin lesions or foreign bodies, range of motion checks, rehabilitation procedures, etc. The

risks associated with these types of procedures include, but are not limited to, reaction to the material(s) used, infection, bleeding, discomfort, muscular-skeletal or internal injuries, nerve damage, paralysis, bruising, worsening of the condition and/or re-injury. Apart from using modified procedures and/or refusal of treatment, no practical alternatives exist.

C. Medication/Drug therapy which may be utilized in the care and treatment of patients. The risks associated with these types of procedures include, but are not limited to, food-drug-herbal interaction; allergic reaction; adverse reactions; and both long term and short-term side effects which vary from medication to medication. Apart from varying the medication prescribed and/or refusal of treatment, no practical alternatives exist.

D. Laboratory testing which may be utilized when taking samples of blood, body fluid, and tissue samples for laboratory analysis. The risks associated with these types of procedures include, but are not limited to, injuries which may occur during the collection of the necessary samples, infections, nerve damage, bleeding bruising, tingling or burning, swelling, allergic reaction, paralysis, and/or loss of limb. Apart from refusal of treatment, no practical alternative exists.

E. Internal tubes such as bladder catheterizations, nasogastric tubes, rectal tubes, drainage tubes, enemas, etc. The risks associated with these types of procedures include but are not limited to, internal injuries, bleeding, infection, allergic reactions, loss of bladder control and/or difficulty urinating after catheter removal. Apart from external collections devices or refusal of treatment, no practical alternatives exist.

6. I consent to and authorize the persons participating in and responsible for my care to use procedures such as those written above, as they may believe reasonably necessary or desirable in their professional judgment, including those procedures that may be unforeseen or not known to be needed at the time this consent is obtained. This consent shall also extend to the treatment of all those conditions which may be unknown or unforeseen at the time this consent is obtained.

7. By signing this form, I acknowledge and understand that I have been informed in general terms of the following:
   A. The nature and purpose of the procedure(s);
   B. The material risks of the procedure(s); and
   C. The practical alternatives to such procedure(s).

   If I have further questions or concerns regarding these procedures, I agree to ask my provider, his/her associates or assistants, and /or office staff to provide additional information.

8. I understand that the practice of medicine is not an exact science and that **NO GUARNATEE OR ASSURANCE HAS BEEN MADE TO ME** concerning the outcome and/or results of any procedures(s).

9. I understand that the Provider, his/her associates or assistants, and/or office staff participating in my care will rely upon my documented medical history, as well as other information obtained

from me, my family or others having knowledge of me, in determining whether to perform the procedure(s) or the course of treatment for my condition and in recommending the procedure.

10. I waive Primary Care of Southwest Georgia, Inc. of any responsibility in dispensing sample medications to me. I understand that the containers are not childproof. I will ask questions if I do not understand the explained potential side effects and directions for taking the sample medications. I understand and accept responsibility in taking these medications.

11. I hereby acknowledge that (participating organization) will share my medical information, as permitted under federal law (HIPAA) and Georgia State law, with my healthcare providers through a health information exchange.

12. We may make your medical information available electronically through state, regional, or national information exchange services which help make your medical information available to other healthcare providers who may need access to it in order to provide care or treatment to you. Participation in health information exchange services also provides that we may see information about you from other participants

13. I consent to have medical students (NP, PA, RN, LPN, MA) present in the room for observation and/or treatment.

YES ☐ NO ☐

(Note: Patient may mark out and initial any procedure and/or section of this form for which consent is not granted)

BEFORE SIGNING YOU MUST READ THIS FORM IN ITS ENTIRETY

Signature of Patient or other persons authorized to sign: **Date:**_____

_____

Please print name: **Reason patient unable to sign:**

_____ _____

Patient/Family verbalizes understanding of Informed Consent information.

Signature of Staff:

_____

Primary Care of Southwest Georgia, Inc.

In an effort to better serve all the patients in our communities we ask you to answer the following questions:

Patient Additional Information **DATE OF BIRTH:**

LAST NAME: **FIRST NAME:** **MIDDLE INITIAL:**

LANGUAGE PREFERENCE:

□ English □ Spanish □ Other Translator Required: □ Yes

RACE:

□ White or Caucasian □ Black or African American □ American Indian or Alaska Native

□ Native Hawaiian or other Pacific Islander □ Other Race

WHO IS YOUR PRIMARY CARE GIVER?

□ Self □ Parent □ Grandparent □ Sibling □ Spouse □ Life Partner □ Caregiver

□ Ward of Court/Guardian □ Unknown

SEXUAL ORIENTATION - WHAT DO YOU THINK OF YOURSELF AS:

Sexual Orientation is defined as to which gender(s) a person is physicaly attracted: to the opposite gender (heterosexual), to the same gender (homosexual), or to both genders (bisexual).

□ Lesbian, Gay or Homosexual □ Straight or Heterosexual □ Bisexual

□ Something else, please describe _____

□ Don't know □ Decline to answer, please explain why_____

GENDER IDENTITY - WHAT IS YOUR CURRENT GENDER IDENTITY? (Check all that apply)

Gender Identity is defined as a person's identification as male or female, which may or may not correspond to the person's body or their sex at birth (meaning what sex was originally listed on a person's birth certificate).

□ Male □ Female □ Female-to-Male (FTM)/Transgender Male/Trans Man

□ Male-to-Female (MTF)/Transgender Female/Trans Woman □ Genderqueer, neither exclusively male nor female

□ Additional Gender Category/(or Other), please specify_____

□ Decline to Answer, please explain why_____

SEX AT BIRTH - WHAT SEX YOU WERE ASSIGNED AT BIRTH ON YOUR ORIGINAL BIRTH CERTIFICATE

□ Male □ Female □ Decline to Answer, please explain why_____

PLEASE INDICATE YOUR PREFERRED PROVIDER:

_____

Signature of Patient/Representative: _____ **Date:** _____

Relationship if other than Patient: _____

Which of the categories best describes your current annual income?

- ☐ Less than $12,000
- ☐ $12,000-18,000
- ☐ $18,000-25,000
- ☐ Over $25,000

How many people live in your home? _____

Thank you for your information!

Primary Care of Southwest GA, Inc.
Partners for a Healthy Community

Revised: 11/08/2018