



Welcome to Primary Care of Southwest Georgia (PCSG)!
Thank you for choosing PCSG for your primary healthcare and
behavioral health needs.

PCSG LOCATIONS

BAINBRIDGE

509 Wheat Avenue
Bainbridge, GA 39819
(229) 416-4421

THOMASVILLE – PRIMARY CARE AND PHARMACY

454 Smith Avenue
Thomasville, GA 31792
(229) 229-227-5510
Pharmacy (229) 516-8877

BLAKELY – PRIMARY CARE AND PHARMACY

360 College Street
Blakely, GA 39823
(229) 723-2660
Pharmacy (229) 359-4060

PCSG – ECES SCHOOL-BASED HEALTH CENTER

283 Martin Luther King Jr. Blvd
Blakely, GA 39823
(229) 261-9884

QUITMAN

907 North Court Street
Quitman, GA 31643
(229) 263-4531

PCSG – TCMS SCHOOL-BASED HEALTH CENTER

4681 US Hwy 84 Bypass
Thomasville, GA 31792
(229) 227-2936

WHAT TO EXPECT FROM OUR OFFICE!



Always remember to bring 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 at 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 or reschedule your appointment for a more convenient time for you.

Patients who fail to call to cancel or reschedule are considered no-show appointments, meaning if you are more than 15 minutes late to your scheduled appointment. 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 your clinic office number which will connect you with our answering service. The answering service will have the on-call provider contact you.



Blakely (229) 723-2660
Thomasville (454 Smith Ave.) (229) 227-5510
Early County Elementary School (PCSG-ECES) (229) 261-9884

Bainbridge (229) 416-4421
Quitman (229) 263-4531
Thomas County Middle School (PCSG – TCMS) (229) 227-2936



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

PRIMARY CARE OF SOUTHWEST GEORGIA – PATIENT DEMOGRAPHIC INFORMATION

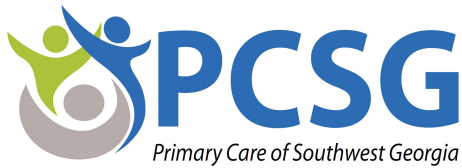
☐ Check here if you need help filling out this application.

Last Name		First Name		Middle Initial	Maiden or Previous Name	
Mailing Address			City	State	County	Zip Code
Contact Number: Home _____ Cell _____ Work _____						
Preferred number for us to call: ☐ Cell ☐ Home ☐ Work		Preferred time to call: ☐ Morning ☐ Afternoon ☐ Evening		Leave Voicemail? ☐ Yes ☐ No		
Patient Web Portal: This is a FREE and secure online portal to view medical records, request medication refills, etc. Personal Email Address _____ Check here if you do not have personal email ☐						
Social Security Number		Marital Status		Sex ☐ F ☐ M	Date of Birth: Month ____ Day ____ Year ____	
Emergency Contact Information				Residence Situation		
Name _____ Relationship to Patient _____ Address _____ City, State, Zip _____ Phone Number(s) _____ Alternate Contact: _____				☐ Rent ☐ Own ☐ Public Housing ☐ Foster Care (Peds) ☐ Homeless ☐ Temporary with Family or Others/Doubled Up ☐ Salvation Army ☐ Rescue Mission ☐ Transitional Housing or Program ☐ Streets		
Have you ever been in the military? Are you a Veteran? Are you a Migrant? Seasonal Farm Worker?		☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No		Advance Directive I have an Advance Directive ☐ Yes ☐ No If no, would you like more information about Advance Directives? ☐ Yes ☐ No ☐ Living Will ☐ Durable Power of Attorney for Health Care		
Currently Employed: ☐ Yes ☐ No		Name & Phone Number of Employer				
Who is your Primary Caretaker: ☐ Self ☐ Parent ☐ Grandparent ☐ Sibling ☐ Spouse ☐ Life Partner ☐ Caregiver ☐ Ward of Court/Guardian ☐ Unknown ☐ Other _____						
Is Patient Covered by Insurance? ☐ Yes ☐ No If yes Check all that Apply *If yes, please give current card(s) to the receptionist.						
☐ Medicare ☐ Part A Only ☐ Parts A & B		☐ Medicaid ☐ CareSource ☐ Peach State ☐ Amerigroup ☐ Planning 4hb		☐ Commercial ☐ Blue Cross ☐ CIGNA ☐ _____		☐ Workers Comp ☐ PCSG's Discount Program ☐ Other _____
Has the Patient Applied for Medicaid/Medicare Coverage? ☐ Yes ☐ No Would you like more information on applying for coverage and other services? ☐ Yes ☐ No Do you have access to regular Dental Care ☐ Yes ☐ No				Financial Statistics For Data Reporting purposes only (Not Specific to Patient) Household Income: _____ How many people living in home: _____		
Name of Other Person Responsible for Bill		Relation to Patient ☐ Parent ☐ Guardian ☐ Other _____ You must provide proof of guardianship/Power of Attorney if not the legal parent.				
Address				Contact Number		
Preferred Lab Provider: *Please note it is the patient's responsibility to verify the lab your insurance company will cover. Without this information you will be responsible for any unpaid lab fees. ☐ Quest Diagnostic ☐ Archbold ☐ Lab Corp. ☐ Solstas ☐ Unknown ☐ Other _____						
Preferred Pharmacy: Name _____ Telephone No.: _____						
Please indicate your PCSG Preferred Provider: _____						
Please indicate if someone referred you to PCSG: _____						

STATISTICAL ANALYSIS DATA**Preferred Language:**☐ English ☐ Spanish ☐ Other _____**Do you need an interpreter:**☐ Yes ☐ No**Barriers****Do you have a** ☐ Speech Impediment and/or ☐ Hearing Impaired**Race:**☐ Asian☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian☐ Native Hawaiian/Other Pacific Islander☐ Native Hawaiian ☐ Other Pacific Islander ☐ Guamanian or Chamorro ☐ Samoan☐ Black/African American☐ American Indian/Alaska Native☐ White☐ More than one race☐ Decline to Answer, please explain why _____**Hispanic Ethnicity:**☐ Hispanic, Latino/a, Spanish origin☐ Mexican, American, Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Another Hispanic, Latino/a, or Spanish Origin ☐ Hispanic, Latino/a, Spanish Origin Combined☐ Not Hispanic/Latino/Spanish origin☐ Prefer Not to Disclose Ethnicity**Sex at Birth – What sex you were assigned at birth on your original birth certificate**☐ Male ☐ Female ☐ Choose not to disclose

The foregoing information is true to the best of my knowledge, and I request PCSG to provide me and/or my family with medical care. I acknowledge my responsibility to pay for services according to the policies established by PCSG. I acknowledge by signing below that I have received a copy of and read the PCSG HIPAA Privacy Policy Notice along with PCSG's Patient's Rights & Responsibilities.

Patient or Guardian Signature X _____ **Date** _____**Relationship if other than Patient** _____



Patient Name _____

Parents' Authorization for Another to Bring Child(ren) to Care

We (I) _____ and _____

Parent(s) and legal guardian(s) of the following named children:

Age _____

Age _____

Age _____

Age _____

We (I) hereby authorize any one of the following individuals:

relationship _____

relationship _____

relationship _____

To consent to any and all medical care and attention for these children which is deemed necessary and appropriate by a physician licensed in the State of Georgia. This consent includes, but is not limited to, medical and surgical intervention and elective as well as emergency care. It also includes immunizations, if needed.

We (I) further agree to reimburse the health care provider for the cost of rendering these services. The children are covered under the following health plan:

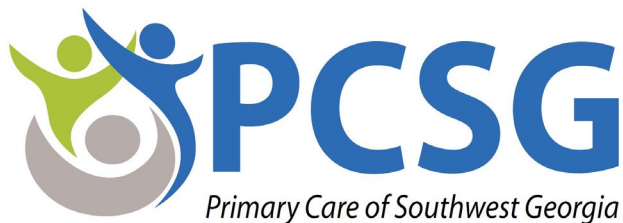
Primary Insurance _____ Policy # _____

Secondary Insurance _____ Policy # _____

SIGNATURE OF PARENT OR LEGAL GUARDIAN:

Print _____ Date _____

Signature _____ Date _____



***PERMISSION TO TREAT AND RELEASE OF HEALTH INFORMATION
MINOR CHILD***

Permission is given for Primary Care of Southwest GA, Inc. and the primary care physician to treat my child and give health information on my minor child,

_____ to the person indicated below:

(Name of Minor Child)

Initial Only One

_____ Only to Myself

_____ Another Individual

Person's Name _____

Relationship _____

I am fully informed as to the content of this form and understand the importance of this grant.

Signed: _____
(Parent)

Date: _____

Signed: _____
(Witness)

Date: _____

Patient Policies/Processes

Please be advised that it is the policy of Primary Care of Southwest Georgia, Inc. to hold the individual receiving services responsible for charges incurred at the time of service. If the patient is a minor, then parents or legal guardian then assume responsibility. Routine office charges are due at the time services are rendered, unless arrangements are made in advance. Medical insurance is filed as a convenience to our patients. **OUR BILL IS WITH OUR PATIENTS, NOT THEIR INSURANCE COMPANIES.** If a problem arises, it is the patients' responsibility to communicate with the insurance company to resolve the problem. If you have any questions, please do not hesitate to ask our staff. We will be glad to help in any way possible. **THANK YOU.**

I have read and fully understand that I am responsible for payment of the services render to the patient. I promise to pay **Primary Care of Southwest Georgia** any unpaid balance due on my account, including reasonable collection charges.

Date

Signature of Guarantor

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Primary Care of Southwest Georgia to furnish information to insurance carriers concerning my illness and hereby assign to the physician(s) all insurance proceeds for medical services rendered to myself or my dependent(s). I understand that I am responsible for charges not covered by insurance.

Date

Signature of Insured

RECEIPT OF PATIENTS RIGHTS AND RESPONSIBILITIES FORM

I have received a copy of Primary Care of Southwest Georgia's Patient Rights and Responsibilities Form.

Date

Signature of Patient or Parent/Guardian

Check for needed forms:

If patient is a minor, will someone other than the guardian bring the patient to their appointments? If yes, please request a ***Minor Consent Form.***

If you are a new patient or have seen another provider, do we have a copy of those records? (please complete an ***Authorization to Release Medical Records Form***)

Do you want to apply for our discount program? (please complete ***Discount Application***)

Patient's Rights and Responsibilities

Policy:

Primary Care of Southwest Georgia, Inc. (PCSG) does not discriminate on the basis of race, color, sex, age, National origin, disability, sexual orientation, political affiliations, religious preference or inability to pay in any consideration of patients.

As a patient of (PCSG) or any other healthcare facility, you have certain rights, including the right to privacy, respect, professionalism, and competent medical care. You also carry certain responsibilities to help optimize the care you receive.

The goal of PCSG is to provide all patients with high quality health care in a manner that clearly recognizes individuals' needs and rights. We also recognize that in order to effectively accomplish this goal, the patient and the health care provider must work together to develop and maintain optimum health. As a result, the below patient rights and responsibilities were written.

Patient Rights

- **Patients** have the right to be treated with respect, consideration, and dignity.
- **Patients** have the right to be provided with appropriate privacy.
- **Patients** have the right to the degree known, to have complete information concerning their diagnosis, evaluation, treatment, and prognosis.
- **Patients** have the right to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.
- **Patients** have the right to refuse to participate in experimental research.
- **Patients** have the right to change healthcare providers if other qualified providers are available.
- **Patients** have the right to make suggestions and express grievances; to receive a personal response to the same, if so requested; and to have continued access to care without intimidation, threat, discrimination, or other retaliatory action. Patients can contact Meredith Kahl, Patient Advocate at (229) 227-5510.
- **Patients** have the right under HIPAA Privacy Rules to the following: to respect limitations on their medical information, to confidential communications, to inspect and request a copy of their medical information, to request amendment for their medical information, to request accounting disclosures, and to a copy of the Notice of Privacy Practices. No patient will be asked to waive his or her rights, including the right to file a complaint regarding privacy with Anna Moore at (229) 723-2660.
- **Patients** have the right to information on the following: services available at PCSG, provisions for after-hours and emergency care, fees for services, payment policies, provider credentialing, and accurate information regarding the competence and capabilities of the organization.
- **Patients** have the right to choose freely among available pharmacies and to change pharmacies based on their needs.

Patient Responsibilities

- **Patients** have the responsibility to provide accurate and complete information to the best of their ability about their current and past illnesses, any medications taken, including over-the-counter products and dietary supplements, and any allergies or sensitivities.
- **Patients** have the responsibility to follow the treatment plan recommended by their healthcare provider or to express concerns regarding their ability to comply.
- **Patients** are responsible for their actions if they refuse treatment or do not follow the healthcare provider's instructions.
- **Patients** have the responsibility to arrive as scheduled for appointments and to cancel in advance appointments they cannot keep.
- **Patients** have the responsibility to become informed of the scope of basic services offered, the costs, and to actively seek clarification of any aspect of participation in PCSG services and programs (including cost) that is not understood.
- **Patients** have the responsibility to accept financial responsibility for all services rendered at PCSG.
- **Patients** have the responsibility to actively participate in their care as part of the organization's Patient Centered Medical Home program.
- **Patients** have the responsibility to behave respectfully toward all healthcare professionals and staff, as well as other patients and visitors.

PRIMARY CARE OF SOUTHWEST GEORGIA (PCSG) TELEHEALTH CONSULTATION CONSENT

Primary Care of Southwest Georgia (PCSG) is dedicated to providing primary care and behavioral health services to Southwest Georgia residents. Because physical and emotional problems often go together, we believe the best care is given when healthcare providers work together. PCSG patients may be referred to providers from other healthcare specialties within the PCSG treatment team; members of the treatment team will share clinical information with each other as is clinically necessary. Reasonable and appropriate efforts have been made to eliminate any confidentiality risk associated with the telehealth consultation, and all existing confidentiality protections under Federal and Georgia state law apply to information disclosed during this telehealth consultation.

Consultations will involve the use of telemedicine equipment and the details of your medical history, current conditions, examinations, plan of care and tests will be discussed through the use of interactive video, audio, and telecommunication technology. The telehealth consultation provider will rely on information collected from you during the consultation session - it is important to provide the most accurate information as possible to assist in developing your plan of care. The evaluation and treatment of children and adolescents will require the involvement of the Parent(s) and/or legal guardian(s).

All existing laws regarding your access to medical information and copies of your medical records apply to this telehealth consultation. These sessions are transmitted via secure, dedicated high-speed lines and are not videotaped, or saved in any way.

This telehealth consultation is a billable service and may be subject to a standard office visit copay or deductible. If the patient has insurance, PCSG will file a claim with the patient's insurance company. Any remaining patient financial obligation will be determined by the patient's insurance company and subject to adjustment based upon PCSG's sliding fee scale (if applicable).

I understand that I may at anytime withdraw my consent and/or refuse my treatment, and will do so verbally and/or in writing to a PCSG provider or staff. Such withdrawal or refusal may result in my medical condition getting worse, staying the same or improving. Such withdrawal will not affect my right to future care or treatment.

I understand, that if I am under the age of 18, I may consent for certain types of telehealth services; if I am 18 years of age or older, I may consent for all other telehealth services, including mental health services; otherwise my parent or legal guardian will need to consent for services. By "Accepting" this consent, (parent or legal guardian "Acceptance", if required) I agree that I have read or had this form read and/or explained to me, that I understand it and that any questions I asked regarding this form or the telehealth consultation have been answered. I understand that I agree to be truthful in providing information. Thus, I hereby "Accept", and consent to this telehealth consultation and treatment for myself or my child(ren) as set forth above, including any procedures or tests that PCSG providers decide are necessary or appropriate. If "Accepting" as the parent or guardian, I hereby represent and warrant that I am legally empowered and entitled to make such decisions.

Health professions are not exact sciences and no guarantees are made concerning the course or effect of treatment proposed by the telehealth provider. Any questions about the benefits, risks, available options, or the limits of confidentiality should be directed to PCSG providers.

By signing below, I agree to participate in a telehealth consultation with Primary Care of Southwest Georgia.

Patient Name (Please Print)

Patient Signature

Date

Primary Care of Southwest Georgia, Inc. Summary of Notice of Privacy Practices

Our Legal Duty: We have a duty to protect the confidentiality of medical information about you. We have a Notice of Privacy Practices explaining ways we may use and disclose your medical information. The Notice also describes your legal rights and obligations regarding the use and disclosure of your medical information. We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Parties Following the Notices: The Notice will be followed by Primary Care of Southwest Georgia, Inc. and its affiliates, together with their health care professionals, staff and volunteers, and those participating in managed care networks with Primary Care of Southwest Georgia, Inc., and other legal entities that provide services to Primary Care of Southwest Georgia (PCSG).

How We May Use and Disclose Medical Information About You: We may use or disclose identifiable health information about you for many reasons including:

- Treatment
- Bill for your services
- Health care operations
- Health oversight activities
- Public health purposes
- Auditing
- National security & protective services
- Research to enhance patient care
- Worker's Compensation; Law enforcement purposes
- Lawsuits and disputes
- Hospital directories
- Fundraising activities (with written consent from patient)
- Activities of managed care networks which we participate
- Activities of our affiliates
- Appointment reminders
- Comply with the Law
- To avert a serious threat to health/safety
- To coroners, medical examiners & directors
- To military command authorities
- As required by law
- Individuals involved in your care or payment.

Your Privacy Rights:

You have the following rights with respect to your health information:

- The right to request confidential communications and alternative means of communication with you.
- The right to request restrictions on certain use of your health information
- The right to inspect and copy certain medical information that we maintain about you either paper or electronic medical record.
- The right to request an amendment of your health information.
- The right to an accounting of certain disclosures of your health information.
- Get a copy of this privacy notice
- File a complaint if you believe your privacy rights have been violated.

Additional Information: Upon request you may review our detailed Notice of Privacy Practices for further information regarding exercising your privacy rights or if you object or request a limitation of the referenced uses of disclosure.

Changes to the Notices: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Patient Acknowledgement: I acknowledge that I have been made aware of the Notice of Privacy Practices for Primary Care of Southwest Georgia. I also acknowledge that I have been provided with an opportunity to ask questions regarding the Notice and its contents.

Patient Name (Printed)

Patient Signature

Date

FOR PCSG PERSONNEL ONLY: (Complete if patient acknowledgement is not obtained)

The patient was made aware of the Notice of Privacy Practices and a good faith attempt was made to obtain the patient's signature acknowledging awareness of the notice, an acknowledgement was not obtained because_____.

PCSG Representative

Date

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.**

Your Rights: When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

- Get a copy of health and claims records: **You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.** We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Ask us to correct health and claims records: You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Request confidential communications: You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
- Ask us to limit what we use or share: You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- Get a list of those with whom **we've** shared information: **You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).** We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- Get a copy of this privacy notice: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- Choose someone to act for you: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- File a complaint if you feel your rights are violated: **You can complain if you feel we have violated your rights by contacting us.** You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Your Choices: For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us.

- In these cases, you have both the right and choice to tell us to: 1) Share information with your family, close friends, or others involved in payment for your care; 2) Share information in a disaster relief situation
- If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- In these cases, we *never* share your information unless you give us written permission: 1) Marketing purposes; 2) Sale of your information.

Our Uses and Disclosures:

How do we typically use or share your health information? We typically use or share your health information in the following ways.

- To help manage the health care treatment you receive. We can use your health information and share it with professionals who are treating you. For example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.
- To run our organization. We can use and disclose your information to run our organization and contact you when necessary. We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans. For example: We use health information about you to develop better services for you.
- To pay for your health services. We can use and disclose your health information as we pay for your health services. For example: We share information about you with your dental plan to coordinate payment for your dental work.

How else can we use or share your health information? We are allowed or required to share your information in other ways - usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes. For more information go to:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

- To help with public health and safety issues. We can share health information about you for certain situations, such as preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, or preventing or reducing a serious threat to anyone's health or safety.
- To do research. We can share your information for health research.
- To comply with the law. We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- To respond to organ and tissue donation requests and work with a medical examiner or funeral director. We can share health information about you with organ procurement organizations. If an individual dies, we can share health information with a coroner, medical examiner, or funeral director.
- To address workers' compensation, law enforcement, and other government requests. We can use or share health information about you for workers' compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, and for special government functions such as military, national security, and presidential protective services.
- To respond to lawsuits and legal actions. We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities: We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. You may change your mind at any time by letting us know in writing. For more information go to:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our website, and we will mail a copy to you.

Primary Care of Southwest Georgia Privacy Official Contact:

Anna Moore, COO
Contact#: 229-723-2660
e-mail: amoore@pcswga.org

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 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. 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

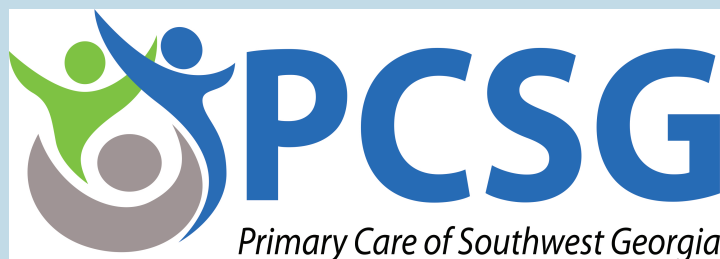
PCSG offers prescription assistance programs (for qualifying participants) which helps with the cost of medications.

Which of the categories best describes your current annual income?

- ☐ Less than \$14,000
- ☐ \$14,000 - \$19,000
- ☐ \$19,000 - \$30,000
- ☐ Over \$30,000

How many people live in your home? _____

Thank you for your information!



Revised: July 2025