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:	**Preferred time to call:**	**Leave Voicemail?**
❑ Cell ❑ Home ❑ Work	❑ Morning ❑Afternoon ❑ Evening	❑ 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

		Advance Directive
Have you ever been in the military?	❑ Yes ❑ No	I have an Advance Directive ❑ Yes ❑ No
Are you a Veteran?	❑ Yes ❑ No	If no, would you like more information about Advance Directives? ❑ Yes ❑ No
Are you a Migrant?	❑ Yes ❑ No	❑ Living Will ❑ Durable Power of Attorney for Health Care
Seasonal Farm Worker?	❑ Yes ❑ No	

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

Sexual Orientation – What do you think of yourself as:
Sexual Orientation is defined as to which gender(s) a person is physically attracted: to the opposite gender (heterosexual), to the same gender (homosexual), or to both genders (bisexual).
❑ Lesbian, Gay or Homosexual ❑ Straight or Heterosexual ❑ Bisexual
❑ Other, please describe _____
❑ Don't know ❑ Unknown
❑ Choose not to disclose

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/Transgender Man/Transmasculine
❑ Male-to-Female (MTF)/Transgender Female/Transgender Woman
❑ Genderqueer, neither exclusively male nor female
❑ Other, please specify_____
❑ Unknown
❑ Choose not to disclose

Pronouns (Check all that apply if you choose to answer – this is not required)
❑ He/Him/His//His'/Himself
❑ She/Her/Her/Hers/Herself
❑ They/Them/Their/Theirs/Themselves
❑ Other, please specify_____
❑ 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 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***)

Primary Care of Southwest Georgia, Inc.

Permission for Release of Health Information

I, _____(please print name), 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:	_____	Name:	_____
Address:	_____	Address:	_____
	_____		_____
Telephone:	_____	Telephone:	_____
Relationship:	_____	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 Signature Date

Consent to Obtain External Prescription History

I, _____ (please print name), 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.

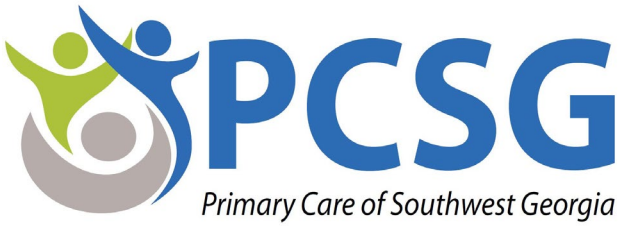
_____ _____

Patient/Guardian Signature Date

_____ _____

Witness Date

Form Number: 101.32D
Revised Date: 3/04/2024



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: _____ Date: _____
(Parent)

Signed: _____ Date: _____
(Witness)

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) herby 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_____

Primary Care of Southwest Georgia

www.pcswga.org

□ *Blakely ● 360 College Street ● Blakely, GA 39823 ● PH 229.723.2660 ● FX 229.723.2663*
□ *Bainbridge ● 509 Wheat Avenue ● Bainbridge, GA 39819 ● PH 229.416.4421 ● FX 229.416.4644*
□ *Quitman ● 907 N. Court Street ● Quitman, GA ● PH 229.263.4531 ● FX 229..263.5787*
□ *Thomasville ● 454 Smith Avenue ● Thomasville, GA 31792 ● PH 229.227.5510 ● FX 229.227.5527*
□ *PCSG - TCMS ● 4681 US HWY 84 Bypass ● Thomasville, GA 31792 ● PH 229.227.2936 ● FX 229.225-5284*
□ *PCSG - ECES ● 283 Martin Luther King Jr. Blvd. ● Blakely, GA 39823 ● PH 229.261.9884 ● FX 229.261.9895*

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO ANOTHER PROVIDER OR FACILITY

Patient Name (Print)	SS or Health Record Number	Patient DOB

Circle: RELEASE TO or RELEASE FROM

Provider's Name: _____

Providers' Address: _____

City_____ State _____ Zip Code _____

Physician's Telephone #_____ Physician's Fax # _____

_____ I authorize (practice/physician's name) to use or release/disclose my health information as described below.

Please identify the information to be released:

☐ Please release my entire record

-OR-

☐ Please release ***only*** the following information (check appropriate boxes and include other information where indicated):

- ☐ Problem list
- ☐ Medication list
- ☐ List of allergies
- ☐ Immunization records
- ☐ Most recent history
- ☐ Behavioral Health records
- ☐ Most recent treatment plan
- ☐ Most recent discharge summary
- ☐ Lab results (please describe the dates or types of lab tests you would like disclosed):_____
  _____
- ☐ X-ray and imaging reports (please describe the dates or types of x-rays or images you would like disclosed):
  _____
  _____
- ☐ Consultation reports (please supply doctors' names):
- ☐ Other (please describe):

The identified information will be used for the following purpose:

☐ My personal records ☐ Sharing with other health care providers as needed ☐ Other (please describe):

Please initial each item below to indicate your understanding.

_____ I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

_____ I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

_____ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

This authorization will expire on (insert date or event): _____

If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

_____ _____

Patient Signature (or Signature of Person Completing Form if Not Patient*) Date

*Relationship to patient: ☐ Parent ☐ Legal Guardian ☐ Other:_____

_____ _____

Witness Signature Date

Form 400.1
Form update 3/04/2024

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 corners, 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 copyof 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

PRIMARY CARE OF SOUTHWEST GEORGIA, INC.

INFORMED CONSENT FOR SIMPLE AND COMMON TREATMENTS & PROCEDURES

BEFORE SIGNING YOU MUST READ THIS FORM IN ITS ENTIRETY

Primary Care of Southwest Georgia, Inc. (PCSG) is dedicated to providing whole person healthcare services to Southwest Georgia residents. Our providers work together to address both primary care and behavioral health needs in our patients. To offer coordinated care, PCSG providers might refer patients to other healthcare providers within the PCSG treatment team. Members of the treatment team will share clinical information, as needed, to improve the quality of care.

For primary care, patients acknowledge and agree to the following:

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 every risk for every procedure used in modern healthcare. However, the physicians, physician assistants, nurse practitioners, and nurse midwives who practice medicine at PCSG 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 associated 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.

For behavioral health care, patients acknowledge and agree to the following:

1. Behavioral health services are voluntary and collaborative, requiring my active participation.

2. The behavioral health provider will review clinical needs and treatment goals with me to help determine the types of interventions that might be the most beneficial, as well as the number of visits or length of time it might take to meet those goals. Some patients may need one to three visits, while others may need more regular visits over a period of months or years.

3. The behavioral health provider will utilize evidence-based treatments to address my needs. There may be risks and benefits to most treatment options. For example, I might discuss difficult and/or unpleasant topics in therapy, which can lead to uncomfortable feelings, like sadness, anger, worry, or guilt. On the other hand, behavioral health services are shown to have several benefits. For example, I might also notice improvements in my mood, sleep, relationships, medical treatment outcomes, and other benefits my provider will review over the course of treatment.

4. I can always choose to end behavioral health services. However, I understand that it is recommended that I discuss this choice with my provider, so they can help me find other resources that might be helpful. If I want to start similar services again, I understand that I can notify my treatment team or the front office.

For all healthcare services, patients acknowledge and agree to the following:

1. I consent to and authorize the persons participating in and responsible for my care to use procedures and treatments, such as those written above, as they may be reasonably necessary or desirable in their professional judgment, including those procedures or treatments 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.

2. 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) and treatment(s);
    b. The material risks of the procedure(s) and treatment(s); and
    c. The practical alternatives to such procedure(s) and treatment(s).

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

3. I understand that healthcare is not an exact science and that **NO GUARNATEE OR ASSURANCE HAS BEEN MADE TO ME** concerning the outcome and/or results of any procedure(s) or treatment(s).

4. 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 any procedure.

5. 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.

6. I hereby acknowledge that Primary Care of Southwest Georgia, Inc. will share my medical information, as permitted under federal law (HIPAA) and Georgia State law, with my healthcare providers through a health information exchange.

7. 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 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.

8. 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

_____

Patient Name (Please Print)

_____ _____

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

_____ _____

Please Print Name of Signature if not patient **Reason patient unable to sign**

Patient/Family verbalizes understanding of Informed Consent information.
Signature of Staff Member:

_____

PCSG
Primary Care of Southwest Georgia

PATIENT'S RIGHTS AND RESPONSIBILITIES

POLICY:
Primary Care of Southwest Georgia, Inc. (PCSG) does not discriminate based on 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 recognizes individuals' needs and rights. We also recognize that to effectively accomplish this goal, the patient and the healthcare 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 an 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.

Revised: June 2019
July 2022
August 2022
March 2024

- **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.

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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 <u>2 weeks</u> before medications are out and have them fax a medication refill request to our office. Please allow at least <u>72 hours</u> 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.

<u>Updated 3/04/2024</u>

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 records. We will ask for this information regularly, at least once a year, 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 before 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 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 secure Patient Portal. This system allows you to review your health record online and also allows you 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 healthcare 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.

Revised: 7/13/2022
Updated 3/04/2024

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!

PCSG
Primary Care of Southwest Georgia

Revised: 1/25/2024