Thomas County Schools
Primary Care of Southwest Georgia-TCMS
School-Based Health Center

Consent for Health Services

Thomas County Schools and Primary Care of Southwest Georgia, Inc. (PCSG) have developed a comprehensive health clinic at Thomas County Middle School (TCMS). This center is staffed with a Board Certified Family Nurse Practitioner and a Licensed Practical Nurse. Our services include diagnosis and treatment of acute illnesses and minor injuries, management of chronic illnesses, routine health physicals, immunizations, health education/promotion, hearing, vision and lab testing.

The primary focus of the clinic is to provide quality, accessible health care to the children of Thomas County Schools in order to impact the children's health, school attendance and academic performance.

I hereby request and authorize that:

Print Student's Name: ____ __________________

First Name Middle Initial Last Name Birth Date

the above named child receives any and all health care services available from, and deemed necessary by, the staff of the TCMS health center and their associated provider agencies. These services may include, but are not limited to, procedures such as evaluation and treatment of acute illness and injuries. Consent is also given for referral of care and if needed, emergency transportation to other physicians, health care professionals, hospitals, clinics, or health care agencies as deemed necessary by the Center and its staff.

The School-Based Health Center encourages each student to involve his/her parent or guardians in health decisions whenever possible. Consent for services is authorized for the length of time the youth is enrolled in the Thomas County School System.

I have read and understand the above information and I give permission for my child's care as described and I consent for my child to be **TRANSPORTED/ACCOMPANIED** by a school designee to and from any school within the Thomas County School System for services at the School-Based Health Center located on the campus of TCMS. I also understand that I may obtain further information regarding the health services offered by the health center by calling (229) 227-2936.

Student Name ____Date:_________________

(PLEASE PRINT)

Parent/Guardian Signature:____________________________________ Date:_________________

Name and Relationship of Legally Responsible Guardian (Please Print):

____ __________________________

Legally Responsible Guardian Name Relationship

Thomas County Schools
Primary Care of Southwest Georgia-TCMS
School-Based Health Center

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 child's** health information to the person that I indicate below.

You may communicate with the following individual regarding **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 Date

Thomas County Schools
Primary Care of Southwest Georgia-TCMS
School-Based Health Center
STUDENT HEALTH QUESTIONNAIRE

School Year 2017-2018

Child's Name: ________________________________ ____________________________ _____________
Last **First** **Middle Initial**

Date of Birth: _______________________ Age: _____ Grade: ______ Student ID #: _____________________
Month/Date/Year

Today's Date: ____________________ School Name: ____________________________________
Month/Date/Year

The information you provide is **STRICTLY CONFIDENTIAL.** Its purpose is to help us give your child better care. We ask that you fill out the form completely, but you may skip any question you do not wish to answer.	
Family Information	
Your Name	How are you related to the above named child?

1. With whom does your child live? (Check All That Apply)
   ______ both natural parents ______ stepmother ______ alone
   ______ mother ______ stepfather ______ brother(s)/ages: ____________________
   ______ father ______ guardian ______ sister(s)/ages: ____________________
   ______ adoptive parents ______ other (explain) ____
2. Does anyone else take care of your child? □ Yes □ No
   If yes, who? ____
3. Does your child have any health problems? □ Yes □ No
   If yes, what? ____
4. Where do you take your child when he/she is sick? _________________________________
5. Where do you take your child for dental care? ____________________________________
6. Does your child have any allergies to any medications? □ Yes □ No
   If yes, what? ____Type of reaction___________
   If yes, what? ____Type of reaction___________
   Does your child have any food allergies or intolerances to insects, environmental, latex □ Yes □ No
   If yes, what? ____Type of reaction___________
7. Is your child taking any medications (over the counter, prescription, homeopathic or herbs)? □ Yes □ No
   If yes, what? ____
8. Has your child ever been hospitalized or had surgery? □ Yes □ No
   If yes, when? ______________ What type? ___________________ Why? _________________
9. Do you have any concerns about your child? □ Yes □ No
   If yes, what? ____
10. Are the child's parents: (Please Circle Answer) Married Separated Divorced Non-Married Parents
    If divorced, when? ____
11. Do the child's parents work outside the home? □ Yes □ No
    If yes, what type of work do they do? Mother _______________ Father ________________

Family Medical History

12. Does the child's mother, father, siblings or grandparents have any of the following?

		If yes, who?			If yes, who?
High Blood Pressure	□ Yes □ No	______	Learning Problems	□ Yes □ No	______
Diabetes	□ Yes □ No	______	Mental Illness	□ Yes □ No	______
Lung Problems	□ Yes □ No	______	Nerve Problems	□ Yes □ No	______
Asthma	□ Yes □ No	______	Drinking Problems	□ Yes □ No	______
Heart Problems	□ Yes □ No	______	Drug Problems	□ Yes □ No	______
Cancer	□ Yes □ No	______	Other ____________	□ Yes □ No	______
Miscarriages	□ Yes □ No				

Family Health Habits

13. How often does your child use a seatbelt (car seat)? (Please Circle Answer)
    A. Never B. Rarely C. Sometimes D. Often E. Always
14. Does your child ride a bicycle, skateboard or roller blade? □ Yes □ No
    If yes, how often does he/she use a helmet? (Please Circle Answer)
    A. Never B. Rarely C. Sometimes D. Often E. Always
15. Does your child need information about safety (strangers or unknown adults, matches, etc.)? □ Yes □ No
16. How many hours of sleep does your child get each night? ______ hours.
17. Do you feel that you live in an unsafe place? □ Yes □ No
18. Have there been any major changes in your family such as: (Check All That Apply)
    ___ moving ___ death of family member ___ violence or serious accident
    ___ physical, emotional, sexual abuse ___loss of job ___ birth ___ other
19. Do you have a gun at home? □ Yes □ No
    If yes, is it locked? □ Yes □ No
20. Does anyone in your household smoke? □ Yes □ No
21. Do you currently smoke cigarettes? □ Yes □ No
    If yes, how many cigarettes do you smoke per day? ______ cigarettes a day

School History

22. Did/does your child attend preschool? □ Yes □ No
23. Do you have any concerns about your child's school performance? □ Yes □ No
    If yes, what? ____
24. Do you have any concerns about your child's relationships with teachers? □ Yes □ No
25. Do you have any concerns about your child's relationships with other students? □ Yes □ No
26. Do you have any concerns about your child's relationships with siblings or other family members? □ Yes □ No
27. If over 4 years old, does your child have a best friend? □ Yes □ No
28. Does your child participate in sports/exercise or have hobbies, special interests or talents? □ Yes □ No

    If yes, what ________________ How often? ________________ How long? _______________

CHILD'S MEDICAL HISTORY

NAME___________________________________BIRTHDATE_____________TEACHER________________________

ILLNESS HISTORY

AIDS/HIV	__Yes__No
Allergies	__Yes__No
Allergic to drugs/latex	__Yes__No
Anemia	__Yes__No
Asthma	__Yes__No
Other Respiratory Problems	__Yes__No
Stomach Ulcers	__Yes__No
Abdominal Pain	__Yes__No
Constipation/Diarrhea	__Yes__No
Serious Digestive Problems	__Yes__No
Chicken Pox Age____	__Yes__No
Ear Problem	__Yes__No
Ear Infections	__Yes__No
Hearing Aid	__Yes__No
Eye Problem	__Yes__No
Wears Glasses	__Yes__No
Physical/Sexual Abuse	__Yes__No
Fainting Spells/Knocked Out	__Yes__No
Frequent Sore Throat	__Yes__No
Headaches	__Yes__No
Heart Murmur	__Yes__No
Heart Problems	__Yes__No
High Blood Pressure	__Yes__No
Thyroid Problems	__Yes__No
Diabetes	__Yes__No
Hemophilia	__Yes__No
Hepatitis	__Yes__No
Injuries (major)	__Yes__No
Musculo-Skeletal Problems	__Yes__No
Broken Bones	__Yes__No
Problems Walking	__Yes__No
Kidney/Urinary Tract Problems	__Yes__No
Frequent Colds	__Yes__No
Lung Problems	__Yes__No
Rheumatic Fever	__Yes__No
Hemophilia	__Yes__No
Underweight	__Yes__No
Menigitis	__Yes__No
Menstration Started Age____	__Yes__No
Menstrual Problems	__Yes__No
Premature Birth Weight______	__Yes__No
Obese	__Yes__No
Rheumatic Fever	__Yes__No
Skin Rashes	__Yes__No
Serious Acne	__Yes__No
Sickle Cell Disease	__Yes__No
Sickle Cell Trait	__Yes__No
Other Blood Disorders	__Yes__No
Seizures/Epilepsy	__Yes__No
Speech Problem	__Yes__No
Tuberculosis	__Yes__No
Underweight	__Yes__No`

Cancer__Yes__No
Other _____________________________

BEHAVIOR STUDY

Thumb Sucking	__Yes__No
Nightmares	__Yes__No
Bedwetting	__Yes__No
Discipline Problems	__Yes__No
Overactive/Hyperactive	__Yes__No
Shy	__Yes__No
Sleeping Problems	__Yes__No
Slow Development	__Yes__No
Learning Disability	__Yes__No
Smoker	__Yes__No
Alcohol	__Yes__No
Inhalants	__Yes__No
Other Drugs _______	__Yes__No
Depression	__Yes__No
Other Behavior Problems	__Yes__No
Other Mental Problems	__Yes__No
Other________________	__Yes__No

Explain any behavior or mental problems noted _______________________________
____
____

PLEASE LIST ANY PRESENT CONCERNS:
____
____
____

***Explain any illnesses marked yes:

____
____
____

DENTAL

Dental Problems __Yes__No
When was your child's last dental visit?
____
How often are your child's teeth brushed?
__Occasionally __Once a Day __Twice __Other
Has your child had a toothache recently? _Yes _No
Has your child had any injury to the teeth or jaws? __Yes __No
Generally speaking, what has been your child's experience with a dentist? __Good __Bad __Very Bad
No experience (the child's first visit) ___

What is the best way to reach you, if we need to? Home Phone #_________________ Cell Phone # _______________________

Mailing Address ____

THANK YOU!

Parent Signature_____________________________ Date: __________________

Parent Email Address_______________________________________

Parent Date of Birth_________________________________

Emergency Contact Name_________________________________

Emergency Contact Phone Number__________________________

PEDIATRIC REGISTRATION FORM

Thomas County Schools
Primary Care of Southwest Georgia-TCMS
229-227-2936 Phone 229-225-5284 Fax
www.pcswga.org

CHILD'S INFORMATION - SEPARATE FORMS MUST BE COMPLETED FOR EACH CHILD IN A FAMILY

CHILD'S FULL NAME (FIRST MIDDLE LAST)			CHILD'S GENDER ☐ MALE ☐ FEMALE	CHILD'S PRIMARY LANGUAGE ☐ ENGLISH ☐ SPANISH ☐ OTHER ________	CHILD'S DATE OF BIRTH
PRIMARY HOME ADDRESS (NO P.O. BOXES)			FAMILY'S PRIMARY EMAIL ADDRESS		
CITY	STATE	ZIP	CHILD'S ETHNICITY ☐ DECLINE ☐ HISPANIC ☐ NON-HISPANIC	CHILD'S RACE ☐ DECLINE ☐ AMERICAN INDIAN OR ALASKAN NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ NATIVE HAWAIN OR PACIFIC ISLANDER ☐ WHITE ☐ OTHER ______________________________	
PRIMARY HOME PHONE	PRIMARY CELL PHONE		PRIMARY WORK PHONE		
Do you prefer to be reached on: (1st contact)	PRIMARY HOME PHONE ☐ PRIMARY CELL PHONE ☐ PRIMARY WORK PHONE ☐				

MOTHER or LEGAL GUARDIAN'S INFORMATION / FATHER or OTHER LEGAL GUARDIAN'S INFORMATION

MOTHER/GUARDIAN'S FULL NAME			FATHER/GUARDIAN'S FULL NAME		
MOTHER/GUARDIAN'S SOCIAL SECURITY #	MOTHER'S MAIDEN NAME OR GUARDIAN'S RELATION TO THE PATIENT *(IFAPPLICABLE)*		FATHER/GUARDIAN'S SOCIAL SECURITY #	CHILD LIVES WITH *(CHECK ONE)* ☐ MOTHER ☐ FATHER ☐ BOTH ☐ OTHER______________________________	
MOTHER/GUARDIAN'S DATE OF BIRTH	MOTHER/GUARDIAN'S MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ SEPERATED ☐ DIVORCED ☐ WIDOWED		FATHER/GUARDIAN'S DATE OF BIRTH	FATHER/GUARDIAN'S MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ SEPERATED ☐ DIVORCED ☐ WIDOWED	
MOTHER/GUARDIAN'S MAILING ADDRESS *CHECK IF SAME AS CHILD*			FATHER/GUARDIAN'S MAILING ADDRESS ☐ *CHECK IF SAME AS CHILD*		
CITY	STATE	ZIP	CITY	STATE	ZIP
MOTHER/GUARDIAN'S HOME PHONE	MOTHER/GUARDIAN'S CELL PHONE		FATHER/GUARDIAN'S HOME PHONE	FATHER/GUARDIAN'S CELL PHONE	
MOTHER/GUARDIAN'S EMPLOYER	MOTHER/GUARDIAN'S WORK PHONE		FATHER/GUARDIAN'S EMPLOYER	FATHER/GUARDIAN'S WORK PHONE	
MOTHER/GUARDIAN'S EMAIL ADDRESS			FATHER/GUARDIAN'S EMAIL ADDRESS		

Please ✓ your annual household income range: ___Less than $12,000 $12,000-$18,000 ______ $18,000-$25,000 ______ Over $25,000

Total number in household (number of people living in home): ______

INSURANCE INFORMATION - THIS SECTION MUST BE COMPLETE OR PAYMENT IN FULL IS DUE AT TIME OF SERVICE

PRIMARY INSURANCE COMPANY NAME	SUBSCRIBER'S NAME	SUBSCRIBER'S DATE OF BIRTH	PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ CHILD SELF ☐ OTHER
SECONDARY INSURANCE COMPANY NAME	SUBSCRIBER'S NAME	SUBSCRIBER'S DATE OF BIRTH	PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ CHILD SELF ☐ OTHER

EMERGENCY CONTACT INFORMATION

Every effort is made to protect our patients' privacy. However, in the case of an emergency in which a parent/legal guardian cannot be reached, we may need to call someone on your child's behalf. Please list below the name of someone your child does not live with and who we have your permission to contact if necessary.

NAME OF PERSON NOT LIVING WITH YOUR CHILD	RELATIONSHIP TO CHILD	EMERGENCY CONTACT'S PHONE NUMBER

PREFERRED PHARMACY

NAME OF PHARMACY	ADDRESS OR INTERSECTION	PHONE (IF KNOWN)	FAX (IF KNOWN)

PLEASE CONTINUE ON THE BACK

Thomas County Schools
Primary Care of Southwest Georgia-TCMS
229-227-2936 Phone 229-225-5284 Fax
www.pcswga.org

PEDIATRIC REGISTRATION FORM

FINANCIAL POLICY & CONSENT FOR TREATMENT

Financial Policy

By signing below, you accept financial responsibility for all services rendered on your child's behalf whether or not you are present on the date of service. Please note that a divorce decree, separation agreement, or any other financial arrangement between two parties does not release your financial obligation to the patient's account. Although another guardian or adult may provide health insurance for the patient, you are still responsible for all remaining balances.

- We file claims to participating insurance companies as a courtesy to you - you are and remain responsible for ensuring full payment. We will bill your insurance company if we are in network and if your insurer accepts claims electronically. You are responsible for confirming our network status with your insurance plan prior to scheduling an appointment. Patients are considered self-pay for services covered by worker's comp or auto insurance.
- If we do not receive payment from your insurance company within 60 days from the date of service, then you will be billed for the balance in full. We will not file claims more than 90 days after the date of service and you must pay the outstanding balance in full.
- Patients with an outstanding balance of 90 days or more must arrange an acceptable payment plan or their account. Payment plans are available for patients with financial difficulty; however, it is your responsibility to contact our office to request assistance before your account becomes delinquent.
- Occasionally during scheduled well child visits a physician will diagnose and treat a problem. When appropriate, problems addressed during preventative exams will be billed as routine care in addition to the well child visit. Some insurance policies do not cover both services. In the event that you schedule a well child visit and a problem is addressed, you may be responsible for an additional co-pay, co-insurance, deductible, or denial after the visit.
- We are required by law to accurately report all services received by our patients. Not all insurance plans cover all services we provide. It is your responsibility to know if you have coverage before services are rendered. In the event that your insurer determines a service is "not covered" under your policy, we cannot change the procedure or diagnosis codes in order for it to be paid.
- All co-pays are due at the time of service regardless of who brings the child in for the appointment. Failing to pay your co-pay at the time of service may result in your appointment being rescheduled.
- When paying with a personal check, a valid photo ID of the check signer is required. Only checks that have been printed with the check signer's name and address will be accepted. All returned checks are assessed a $35.00 service charge. Postdated checks are not accepted.
- If for any reason you must cancel or reschedule your appointment(s), please notify our office at least 24 hours in advance. Patients that no-show 2 times in 6 months will not be allowed to schedule appointments. You will be required to walk-in and wait for an appointment to open up. If you are more than 1 5 minutes late for your appointment, you will need to reschedule your appointment.

Consent for Treatment

As the parent or legal guardian of the patient listed below, I do hereby consent to the performance of routine diagnostic procedures and/or medical treatment as deemed necessary or advisable by my child's physician(s) at Primary Care of Southwest Georgia, Inc.. (PCSG) I hereby authorize PCSG to apply for benefits on my child's behalf for all services rendered. I certify that the information I have provided regarding my child's insurance coverage is correct. I further authorize the release of any and all information necessary for my child's insurance company to determine benefits for services rendered. I request payment of authorized benefits be made payable to PCSG on my child's behalf. I have read and agree to the financial policies stated above. I understand that I am ultimately responsible for the balance on my child's account for all services rendered.

Consent for Medical Treatment: I voluntarily consent to and authorize care encompassing all diagnostic and therapeutic treatments considered necessary or advisable by the health care provider (HCP) including seronoloy testing for Hepatitis B, C, HIV, and UA's in the event my blood and or/body fluids is suspected to have come in direct contact with any health care worker, to determine if my blood has contagious viruses. I understand that all the patients will see a HCP and/or Licensed Clinical Social Worker and that PCSG participates in preceptorships and clinical rotations for pre-med, medical, nursing, and medical assistant students. All student evaluations are under the direct supervision of the attending physician/provider.

I consent to have medical students (NP, PA, RN, LPN, MA) present in the room for observation and treatment. YES _____ NO ______

Authorization to Release Medical Information: I hereby authorize PCSG to release any information, including Behavioral Health, necessary for my course of treatment. I understand that my records are protected by HIPPA Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to the provider.

Acknowledgement of Privacy Notice: PCSG Notice of Privacy Practices is and was available to read.

Authorization to Obtain External Prescription History: I authorize PCSG to view my external prescription history in the RxHub service (including medications from all physicians past and present) in order to document allergic reactions, adverse side effects, dosages and other pertinent information to ensure proper treatment and management of my health care.
I consent to exchange data with external care settings for a more detailed medical record to assist in my care and treatment.

Parent/Guardian's Name & Signature

Child's Name

____
Print Parent/ Guardian's Full Name

____
Print Child's Name

____
Date of Birth

____
Parent/ Guardian's Signature

____
Date of Signature

AUTHORIZED INDIVIDUALS ALLOWED TO ACCOMPANY MY CHILD FOR MEDICAL CARE AND RECEIVE MEDICAL RESULTS

Please list anyone who has your permission to bring your child to our office for medical care and/or vaccinations in your absence and/or who is authorized to receive your child's medical information. In the event of an emergency, only people you authorize in writing, per HIPAA requirements, will be able to accompany your child for treatment without you being present.

NAME OF AUTHORIZED INDIVIDUAL (Last, First, Middle Initial)	DATE OF BIRTH	RELATIONSHIP TO CHILD	PRIMARY PHONE
NAME OF AUTHORIZED INDIVIDUAL (Last, First, Middle Initial)	DATE OF BIRTH	RELATIONSHIP TO CHILD	PRIMARY PHONE

NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

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.**

EFFECTIVE DATE: January 8, 2018

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Our Health Center provides patients with access to their health information through a secure patient portal.

Revised January 8, 2018
Senior Management Approval: 01/08/18

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 using the information on page 1.
- 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. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- 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:

- Marketing purposes
- 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.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

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.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

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 have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

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
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

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.

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.

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

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
- For special government functions such as military, national security, and presidential protective services

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. 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**.**

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 web site, and we will mail a copy to you.

Primary Care of Southwest Georgia Privacy Official Contact:

Angie McVey, *COO*

Contact #: 229-723-2660; ext.: 7132

e-mail: amcvey@pcswga.org

Revised January 8, 2018

Senior Management Approval: 01/08/18