Thomas Co. Schools | Primary Care of Southwest Georgia-TCMS | School Based Health Center | Patient Information

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

Are you an employee or student of Thomas County School Systems (check one)? ☐ Employee ☐ Student

Last Name	First Name	Middle Initial	Maiden or Previous Name

Mailing Address	City	State	County	Zip Code

Contact Number:
Home ____________ Cell ____________ Alternate ____________ Leave Message? ________

Preferred number for us to call: ☐ Cell ☐ Home ☐ Work

Also notify using: ☐ Email ☐ Text Message ☐ Patient Portal
Email Address: ________________________________

Preferred time to call: ☐ Morning ☐ Afternoon ☐ Evening

Pharmacy:

Social Security Number	Marital Status	Sex ☐ F ☐ M	Date of Birth: Month _____ Day _____ Year _______

Emergency Contact Information

Name ____________________
Relationship to Patient ____________________
Address ____________________
City, State, Zip ____________________
Phone Number(s) ____________________
Alternate Contact: ____________________

Residence Situation

☐ Permanent
☐ 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? ☐ Yes ☐ No
Are you a Veteran ☐ Yes ☐ No
Are you a Migrant ☐ Yes ☐ No
Seasonal Farm Worker? ☐ 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

Race: ☐ Black/African American ☐ White ☐ Multiple Race ☐ Asian ☐ Native Hawaiian ☐ Pacific Islander ☐ American Indian/Alaska Native **Hispanic Ethnicity:** ☐ Yes ☐ No ☐ Prefer Not to Disclose Race/Ethnicity

Preferred Language: ____________________

Do you need an interpreter? ☐ Yes ☐ No

Currently Employed: ☐ Yes ☐ No

Name & Number of Employer

Primary Care Provider:

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
- ☐ Well Care
- ☐ Peach State
- ☐ Amerigroup
- ☐ Planning 4hb

☐ Commercial
- ☐ Blue Cross
- ☐ CIGNA
- ☐ ____________

☐ Workers Comp

☐ PCSG's Discount Program

☐ Other ____________

Contracted Lab ☐ Quest Diagnostic ☐ Archbold ☐ Lab Corp. ☐ Solstas ☐ Unknown ☐ Other ____________
***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.**

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

Barriers
Do you have a
☐ Speech Impediment **and/or**
☐ Hearing Impaired?

Financial Statistics
For Data Reports (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

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 ______________________

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:

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

Thomas County Schools
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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** health information to the person that I indicate below.

You may communicate with the following individual regarding **my** 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

Consent to Obtain External Prescription History

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

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

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

______________________________ ______________________
Patient/Guardian Date

______________________________ ______________________
Witness Date

Thomas County Schools
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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
- 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.

Secretary of the US Department of Health and Human Services

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

Primary Care of Southwest Georgia-TCMS

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

Patient Additional Information **DATE OF BIRTH:**

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

LANGUAGE PREFERENCE:

□ English □ Spanish □ Other Translator Required: □ Yes

RACE:

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

□ Native Hawaiian or other Pacific Islander □ Other Race

WHO IS YOUR PRIMARY CARE GIVER?

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

□ Ward of Court/Guardian □ Unknown

SEXUAL ORIENTATION - WHAT DO YOU THINK OF YOURSELF AS:

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

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

□ Something else, please describe ____

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

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

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

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

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

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

□ Decline to Answer, please explain why____

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

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

PLEASE INDICATE YOUR PREFERRED PROVIDER:

____

Signature of Patient/Representative: ______________________________ **Date:** ____________________

Relationship if other than Patient: ______________________________

Form Number:

Revised Date: 8/8/2017