Stephens County Hospital Physician Group – Primary Care

218 Falls Road
Toccoa, GA 30577
Phone: 706-282-5840
Fax: 844-971-7178

Patient Information		
Last Name:	**First Name:**	**Middle Name:**
Date of Birth:	**Gender:** □ **Male** □ **Female**	**SSN:**
Mailing Address:		
City:	**State:**	**Zip Code:**
Street Address (if different from mailing):		
City:	**State:**	**Zip Code:**
Ethnicity: □ Hispanic □ Non-Hispanic	**Race:** □ Asian □ Black or African American □ White □ Other	
Home Phone:	**Cell Phone:**	**Work Phone:**
Email:		
Marital Status: □ Married □ Divorced □ Single □ Separated □ Widowed □ Partner		
Employer:		

Legal Guardian Information (Medical Power of Attorney- Please provide documentation)		
Last Name:	**First Name:**	**Middle Name:**
Relationship to Patient:		
Home Phone:	**Cell Phone:**	**Work Phone:**
Email:		
Mailing Address:		
City:	**State:**	**Zip Code:**

Emergency Contacts (Please list two contacts)		
Name:	**Relationship to Patient:**	**Phone:**
Name:	**Relationship to Patient:**	**Phone:**

Primary Insurance	**Secondary Insurance**
Insurance Name:	**Insurance Name:**
Policy Number:	**Policy Number:**
Subscriber Name:	**Subscriber Name:**
Patient Relation to Subscriber: □ Self □ Child □ Other	**Patient Relation to Subscriber:** □ Self □ Child □ Other
Subscriber SSN:	**Subscriber SSN:**
Subscriber Date of Birth:	**Subscriber Date of Birth:**

By signing below, you attest that the information provided above is accurate and accept any consequences, financial or otherwise, which may result as a failure to provide accurate information. You further accept the responsibility of immediately updating out office with any changes to this information should this information change.

_____ _____

Patient /Parent /Legal Guardian Signature **Date**

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Medical History

Patient Name: **Date of Birth:**

Present Health Concerns:

Medications

Medication Name	Dose	Frequency

Allergies

Allergy	Reaction or Side Affect

Personal Medical History

Please indicate whether the patient has any of the following medical problems

- □ **Asthma**
- □ **Anemia**
- □ **Anxiety**
- □ **Constipation**
- □ **Convulsions / Seizures**
- □ **Depression**
- □ **Diabetes**
- □ **Diarrhea**
- □ **Heart Disease**
- □ **High Blood Pressure**
- □ **High Cholesterol**
- □ **Seasonal Allergies**

Other:

Hospitalizations

Please list all prior hospitalizations and dates

Reason	Date

Immunizations

Please list immunizations the patient has received at other health care facilities and your best estimate of the month and year

Hepatitis A:	**Measles:**	**Mumps:**	**Rubella:**	**Flu:**
Hepatitis B:	**Shingles:**	**Tdap:**	**Varicella:**	**Polio:**

Communicable Diseases

Please indicate any that the patient has ever had and your best estimate of the month and year

□ **Chickenpox** Date:	□ **Measles** Date:	□ **Mumps** Date:
□ **Rubella** Date:	□ **Meningitis** Date:	□ **Tuberculosis (TB)** Date:

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Medical History

Patient Name:	**Date of Birth:**

Review of Systems

*Please indicate any **current** problems your child has in the list below*

□ **Fevers/chills/sweats**	□ **Dizziness/Light-headedness**	□ **Incontinence**	□ **Difficulty breathing**
□ **Unexplained weight loss**	□ **Numbness**	□ **Discharge from penis**	□ **Muscle/joint pain**
□ **Fatigue/weakness**	□ **Memory loss**	□ **Abnormal vaginal bleeding**	□ **Rash**
□ **Chest pain/discomfort**	□ **Loss of coordination**	□ **Vaginal Discharge**	□ **Skin problems**
□ **Excessive Thirst or urination**	□ **Change in vision**	□ **Painful urination**	□ **Problems with sleep**
□ **Abdominal pain**	□ **Nearsighted**	□ **Difficulty hearing**	□ **Depression**
□ **Blood in bowel movement**	□ **Farsighted**	□ **Seasonal allergies**	□ **Developmental delays**
□ **Nausea/vomiting/diarrhea**	□ **Breast lump/discharge**	□ **Problem with teeth/gums**	□ **Behavioral disorders**
□ **Headaches**	□ **Nighttime urination**	□ **Coughing/wheezing**	□ **Anxiety/stress**

Surgical History

Surgery	**Date**

Social History

Do you drink caffeine?	**Do you drink alcohol?**	**Do you smoke Tobacco?**	**Do you use illicit drugs?**
□ Yes □ No **How often?**	□ Yes □ No □ Beer □ Wine □ Liquor Qty:_____ Frequency:_____	□ Yes □ No □ Quit **Type:** □ Cigarettes □ Vape □ Cigar **Packs per week: _____** **For _____ years**	□ Yes □ No **Type:** □ Marijuana □ Cocaine □ Heroin □ Methamphetamine □ Opioids □ Other:_____

Family Medical History

Please check all that apply

	Living Status	**Asthma**	**Diabetes**	**High Blood Pressure**	**Heart Disease**	**Stroke**	**Heart Attack**	**Cancer**	**Depression**
Mother		☐	☐	☐	☐	☐	☐	☐	☐
Father		☐	☐	☐	☐	☐	☐	☐	☐
Siblings		☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandmother		☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandfather		☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandmother		☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandfather		☐	☐	☐	☐	☐	☐	☐	☐

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Assignment of Benefits	
Patient Name:	**Date of Birth:**

SCHPG Primary hereinafter referred to as "Primary Care is a subsidiary of Stephens County Hospital and is committed to providing patients with information regarding their coverage and financial responsibilities. In consideration of services provided by Primary Care, the Patient or undersigned representative ("Guarantor") acting on behalf of the Patient agrees to the following:

Non-Medicare Patient/Guarantor Responsibility for Payment

In return for Medical Treatment/Services rendered to the Patient, Guarantor understands and unconditionally agrees to the following:

- Guarantor agrees to pay all co-payments, deductibles, co-insurances, or any charges denied by the patient's insurance which are deemed Patient Responsibility.
- Guarantor understands and agrees that he/she will be charged the Stephens County Hospital Physician Group standard charge master rates for all services not covered by a Payor or that are self-pay.
- Guarantor specifically agrees to pay for any services, which are determined not to be covered by any health benefit plan or insurance company.
- Patient is aware that he/she is not relieved of liability by any extension of time granted for the payment of these charges should payment extensions or payment plans be agreed upon by both parties.
- If WORKWELL requires legal assistance to collect an account, Patient agrees to pay the cost incurred for such collections.

Assignment of Insurance or Health Plan Benefits

Patient acknowledges the assignment and authorization for direct payment to Primary Care for all insurance and health plan benefits and settlements whether hospital or clinic, medical or liability insurance including but not limited to, the proceeds of any settlement or judgment of any third party claim as payment for any and all services performed at a Stephens County Hospital entity. Patient agrees that the insurance company's or health plan's payment to Primary Care pursuant to this authorization shall discharge the insurance company's or health plan's obligations to the extent of such payment.

Filing of Third Party Claims

Guarantor acknowledges that upon proof of coverage, Primary Care will submit a claim for payment of insurance benefits and accept payments from third party payors ("Payors") to be credited to Patient's account as they are received. Guarantor agrees that the filing of insurance claims is performed as a service and in no way relieves Guarantor of the obligation to pay in full. Additionally the Patient acknowledges the following:

- Guarantor is responsible to follow up with any insurance company or employer within 30 days to see that Patient's bill is paid promptly.
- Guarantor understands that he/she is financially responsible for charges not paid according to this agreement. If Guarantor overpays the amount owed on his/her account, Guarantor assigns credit to be applied to any other existing unpaid accounts ("Other Accounts") for which the Patient or the insured or guarantor is also responsible for any account owned by Stephens County Hospital. Any money remaining after the Patient's account and Other Accounts have been paid in full will be refunded to the patient or guarantor.
- Insurance companies will often deny claims when the insurance is not presented at the time of service. Please contact Primary Care in the event you are made aware that a claim has been denied. Otherwise your account may be considered self-pay/uninsured and you will be responsible for the total bill.

Assignment of Medicare Benefits

Guarantor certifies that the information given in applying for payment under Title XVIII of the Social Security Act is correct. Guarantor requests that the payment of authorized benefits be made on Patient's behalf to the provider of Medical Treatment/Services. Guarantor assigns the benefits payable for Medical Treatment/Services rendered by Primary Care and all Healthcare Professionals rendering care and/or treatment to Patient and authorizes Primary Care and Healthcare Professionals to submit claims to Medicare for payment. Patient authorizes any holder of medical or other information to release to Medicare and its agents any information needed to determine these benefits or benefits for related services. Patient understands he/she is responsible for any deductibles, co-payments and/or non-covered services as defined by Medicare to be paid in accordance with all terms and conditions specified herein.

Assignment of Medicaid Benefits

Guarantor certifies that the information given in applying for payment under Title XIX of the Social Security Act is correct. Guarantor authorizes any holder of medical or other information to release to the Social Security Administration or its intermediaries or carrier's any and all information needed for this or related Medicaid claims. Patient requests payment of authorized benefits be made on Patient's behalf to the provider of Medical Treatment/Services. Patient assigns the benefits payable for Medical Treatment/Services rendered by Primary Care and all Healthcare Professionals rendering care and/or treatment to Patient and authorizes Primary Care and Healthcare Professionals to submit claims to Medicaid for payment.

Authorization to Release Information

Primary Care is authorized to release information contained in the patient record. The information authorized to be released shall include, but is not limited to, infectious or contagious disease information, including HIV or AIDS-related evaluations, diagnosis or treatment; information about drug or alcohol abuse or treatment of same and/or psychiatric or psychological information. Guarantor waives any privilege pertaining to such confidential information. Primary Care, its agents and employees are hereby released from any and all liabilities, responsibilities, damages, claims and expenses arising from the release of information as authorized above. Reasons for releasing a Patient's record include, but are not limited to, insurance company(s), their agents or other third party payor and/or government or social service agencies which may or will pay for any part of the medical/hospital expenses incurred or authorized by representatives of Primary Care, as mandated by law, or to alternate care providers, including community agencies and services, as ordered by Patient's physician or as requested by Patient or Patient's family for post-hospital care. GUARANTOR ACKNOWLEDGES AND AGREES THAT PATIENT'S RECORDS WILL BE AVAILABLE TO ALL Primary Care AFFILIATED ENTITIES AND PROVIDERS, AND TO NON-Primary Care AFFILIATED REFERRING PROVIDERS IN COMPLIANCE WITH THE PROVISIONS OF MEANINGFUL USE. Patient also agrees, in order for Primary Care to service accounts or to collect liabilities owed, to receive contact by telephone at any telephone number associated with their record, including wireless telephone numbers, which could result in charges to Patient. Primary Care or its agents may also contact Patient by sending text messages or emails, using any email address Patient provides. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable

_____	_____	_____
Patient / Guarantor Name (Printed)	**Patient / Guarantor Signature**	**Date**

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Conditions for Service and Consent for Treatment	
Patient Name:	**Date of Birth:**

IMPORTANT: DO NOT SIGN THIS FORM WITHOUT READING AND UNDERSTANDING ITS CONTENTS

In consideration of services provided by Primary Care, as subsidiary of Stephens County Hospital (SCH) and Stephens County Hospital Physician Group (SCHPG), the Patient or undersigned representative ("Guarantor") acting on behalf of the Patient agrees and consents to the following:

Consent to Routine Medical Treatment/Services

Guarantor consents to the rendering of Medical Treatment/Services as considered necessary and appropriate by the physician or other practitioner, a member of the Stephens County Hospital medical staff who has requested care and treatment of Patient, and others with staff privileges at Stephens County Hospital, DBA, Primary Care. Medical Treatment/Services may be performed by "Healthcare Professionals" (physicians, nurses, technologists, technicians, physician assistants or other healthcare professionals). Guarantor authorizes the attending or other practitioner, the medical staff of SCH and SCH to provide Medical Treatment/Services ordered or requested by attending or other practitioner and those acting in his or her place. The consent to receive "Medical Treatment/Services" includes, but is not limited to: clinical care; examinations; laboratory procedures; medications; infusions; drugs; supplies; local anesthesia; surgical procedures and medical treatments; radiation therapy; recording/filming for internal purposes (i.e., identification, diagnosis, treatment, performance improvement, education, safety, security) and other services which Patient may receive. In the event WORKWELL determines that Patient should provide blood specimens for testing purposes in the interest of the safety of those with whom Patient may come in contact; Guarantor consents to the withdrawing and testing of Patient's blood and to the release of test information where this is deemed appropriate for the safety of others.

Explanation of Risk and Treatment Alternatives

Guarantor acknowledges that the practice of medicine is not an exact science and that **NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO THE PATIENT** concerning the outcome and/or result of any Medical Treatment/Services. While routinely performed without incident, there may be material risks associated with each of these Medical Treatment/Services. Guarantor understands that it is not possible to list every risk for every Medical Treatment/Services and that this form only attempts to identify the most common material risks and the alternatives (if any) associated with the Medical Treatment/Services. Guarantor also understands that various Healthcare Professionals may have differing opinions as to what constitutes material risks and alternative Medical Treatment/Services. By signing this form, Guarantor consents to Healthcare Professionals performing Medical Treatment/Services as they may deem reasonably necessary or desirable in the exercise of their professional judgment, including those Medical Treatment/Services that may be unforeseen or not known to be needed at the time this consent is obtained; and Guarantor acknowledges that Guarantor has been informed in general terms of the nature and purpose of the Medical Treatment/Services; the material risks of the Medical Treatment/Services and practical alternatives to the Medical Treatment/Services. The Medical Treatment/Services may include, but are not limited to the following:

- Needle Sticks, such as shots, injections, intravenous lines or intravenous injections (IVs). The material risks associated with these types of Procedures include, but are not limited to, nerve damage, infection, infiltration (which is fluid leakage into surrounding tissue), disfiguring scar, loss of limb function, paralysis or partial paralysis or death. Alternatives to Needle Sticks (if available) include oral, rectal, nasal or topical medications (each of which may be less effective).
- Physical Tests, Assessments and Treatments such as vital signs, internal body examinations, wound cleansing, wound dressing, range of motion checks and other similar procedures. The material risks associated with these types of Procedures include, but are not limited to, allergic reactions, infection, severe loss of blood, muscular-skeletal or internal injuries, nerve damage, loss of limb function, paralysis or partial paralysis, disfiguring scar, worsening of the condition and death. Apart from using modified Procedures, no practical alternatives exist.
- Administration of Medications via appropriate route whether orally, rectally, topically or through Patient's eyes, ears or nostrils, etc. The material risks associated with these types of Procedures include, but are not limited to, perforation, puncture, infection, allergic reaction, brain damage or death. Apart from varying the method of administration, no practical alternatives exist.
- Drawing Blood, Bodily Fluids or Tissue Samples such as that done for laboratory testing and analysis. The material risks associated with this type of Procedure include, but are not limited to, paralysis or partial paralysis, nerve damage, infection, bleeding and loss of limb function. Apart from long-term observation, no practical alternatives exist.

If Guarantor has any questions or concerns regarding these Medical Treatment/Services, Guarantor will ask Patient's attending provider to provide Patient with additional information. Guarantor also understands that Patient's attending or other provider may ask Patient to sign additional informed consent documents concerning these or other Medical Treatment/Services.

Patient Survey

Guarantor authorizes Primary Care and/or its authorized representative to contact Patient after discharge for the purpose of conducting patient satisfaction surveys and other studies.

Patient Rights and Personal Valuables

Guarantor acknowledges that Patient has received a copy of Patient Rights and has verified the information utilized during this registration and confirms its accuracy. Primary Care shall not be liable for the loss or damage of any personal belongings, including but not limited to money, cell phones, laptops, electronic devices, jewelry, hearing aids, computers or dentures.

_____	_____	_____
Patient / Guarantor Name (Printed)	**Patient / Guarantor Signature**	**Date**

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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.

Primary Care and its affiliates, including its Hospitals, Clinics, Employed Physicians, our foundations and other facilities ("Primary Care Providers") are all committed to keeping your health information private. We are required by the federal Privacy Rule to protect your medical information (called "protected health information" or "PHI") and to provide you with this Notice of Privacy Practices (the "Notice") describing our legal duties and privacy practices. WORKWELL Healthcare professionals, employees, students, volunteers and business associates are all required to follow our privacy practices in caring for our patients. In certain circumstances, pursuant to this Notice, patient authorization or applicable laws and regulations, PHI can be used by Primary Care Providers or disclosed to other parties as described below.

Uses and Disclosures for Treatment, Payment and Health Care Operations: Primary Care Providers may use or disclose your PHI for the purposes of treatment, payment and health care operations, described in more detail below, without obtaining written authorization from you.

For Treatment: Primary Care Providers may use and disclose PHI in the course of providing, coordinating or managing your medical treatment, including the disclosure of PHI for treatment activities of another health care provider. For example, if you are being treated by a primary care physician, that physician may need to use/disclose PHI to a specialist physician whom he or she consults regarding your condition, or to a nurse who is assisting in your care.

For Payment: Primary Care Providers may use and disclose PHI in order to bill and collect payment for the health care services provided to you. For example, a Primary Care Provider may need to give PHI to your health plan in order to be reimbursed for the services provided to you. We may also disclose PHI to our business associates, such as billing companies, and claims processing companies.

For Health Care Operations: Primary Care Providers may use and disclose PHI as part of their operations, including for quality assessment and improvement, such as evaluating the treatment and services you receive and the performance of our staff in caring for you. Other activities include training, learning purposes, compliance and risk management activities, planning and development and administration.

For Medical Research: Research is vital to the advancement of medical science. Federal regulations permit use of PHI in medical research, either with your authorization or without your authorization when the research study is reviewed and approved by an Institutional Review Board or privacy board before any study begins, or for reviews preparatory to research as permitted by law, or for research on decedent's information as permitted by law.

As Required by Law and Law Enforcement: Primary Care Providers may use or disclose your PHI when required by law without your authorization. We may also disclose PHI when ordered to in a judicial or administrative proceeding, in response to subpoenas or discovery requests, to identify or locate a suspect, fugitive, material witness or missing person, when dealing with gunshot and other wounds, about criminal conduct, to report a crime, its location or victims, or the identity, description or location of a person who committed a crime or for other law enforcement purposes.

For Public Health Activity: Primary Care Providers may disclose PHI to government officials in charge of collecting information about births and deaths, preventing and controlling disease, reports of child abuse or neglect and of other victims of abuse, neglect or domestic violence, reactions to medications or product defects or problems, or to notify a person who may have been exposed to a communicable disease or may be at risk of contracting or spreading a disease or condition.

For Health Oversight Activities: Primary Care Providers may use or disclose certain information to the government for authorized oversight activities including inspections, audits, licensure and other investigations of our providers or related matters.

Organ, Eye and Tissue Donation: Primary Providers may release PHI to organ procurement organizations to facilitate organ, eye and tissue donation and transplantation.

Coroners, Medical Examiners, Funeral Directors and Individuals Involved in Your Health Care or Payment for Your Health Care: Primary Care Providers may disclose PHI to coroners, medical examiners and funeral directors for the purpose of identifying a decedent, determining a cause of death or otherwise as necessary to enable these parties to carry out their duties consistent with applicable law.

Uses and Disclosures for Involvement in Your Care: Unless you object, Primary Care Providers may disclose your PHI to a family member, other relative, friend or other person you identify as involved in your health care or payment for your health care. We may use or disclose information to family members or others involved in the care of deceased individuals. We may also notify those people about your location or condition. Upon request, PHI may be released fifty (50) years after an individual's death.

To Avoid a Serious Threat to Health or Safety or in Disaster Relief Efforts: Primary Care Providers may use and disclose PHI to law enforcement personnel or other appropriate persons, to prevent or lessen a serious threat to the health or safety of a person or the public. We may also disclose information about you to an organization assisting in disaster relief efforts so that your family can be notified about your location, condition and status. If you do not want us to disclose information for disaster relief efforts, we will not do so unless we must respond in an emergency.

Specialized Government Functions: Primary Care Providers may use and disclose certain PHI if you are military personnel or a veteran. We may also disclose PHI to authorized federal officials for intelligence, counterintelligence and other national security activities, and for the provision of protective services to the President or other authorized persons or foreign heads of state.

Workers' Compensation: Primary Care Providers may disclose PHI to comply with workers' compensation or other similar laws that provide benefits for work-related injuries or illnesses.

Fundraising Efforts: Your PHI may be used to contact you or may be disclosed for Primary Care Provider fundraising efforts. Such disclosure would be limited to demographic information, such as your name, address, other contact information such as your phone number, age, gender and date of birth, the dates you required treatment or services at a Primary Care Provider, department of service information, treating physician, outcome information and health insurance status. You have a right to opt out of receiving such fundraising communications and in the event you are contacted for fundraising, you will be given the opportunity to opt out. Information about births and deaths, preventing and controlling disease, reports of child abuse or neglect and of other victims of abuse, neglect or domestic violence, reactions to medications or product defects or problems, or to notify a person who may have been exposed to a communicable disease or may be at risk of contracting or spreading a disease or condition.

For Health Oversight Activities: Primary Care Providers may use or disclose certain information to the government for authorized oversight activities including inspections, audits, licensure and other investigations of our providers or related matters.

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Acknowledgement of Receipt of "Notice of Privacy Practices"	
Patient Name:	**Date of Birth:**

I hereby acknowledge that I have received a copy of the Primary "Notice of Privacy Practices."

_____

Patient/Guarantor Name (Printed)

_____

Patient/Guarantor Signature

_____

Date