Community Health Care Systems, Inc.

Wrightsville Tennille Sandersville Jeffersonville Irwinton Dublin Gray McRae Wrens Warrenton Gibson Sparta Milledgeville

Patient Information and Registration Record

Last Name: First Name: Middle Initial:

Street Address: | P.O. Box

City, State, and Zip | County

Home Phone: | Work Phone: | Cell Phone:

Social Security Number:

Date of Birth: / /

Contact Preference: □Mail □Voicemail-Home □Voicemail-Cell □Text □Email:

Employment Status: □Employed Full-time □Employed Part-time □Unemployed □Student Full-time □Student Part-time □Not a Student

Billing Information

Person Responsible for Bill:

Relationship to Patient: | Social Security Number:

Responsible party's employer and address:

Street Address | Home Phone:

City, State, and Zip | Work Phone: | Other:

Insurance Information

Do you have insurance other than Medicare or Medicaid? ☐Yes ☐No

Do you have Medicare? ☐Yes ☐No | Do you have Medicaid? ☐Yes ☐No

Do you have prescription benefits with you insurance? ☐Yes ☐No

Financial Assistance Information

We offer a sliding fee scale for qualified patients. Are you interested in applying for assistance?

☐ Yes- Please give me an application

☐ No- I am not interested in applying for any financial assistance. I understand I can apply at a later date.

(A separate application and verification of income is required for this service.)

Which category best describes your current yearly income? □<$10,000 □$10,000-14,999 □$15,000-19,999 □$20,000-29,999 □$30,000-49,999 □$50,000-79,999 □over $80,000 □prefer not to answer

Emergency Contact Information

1) Person to contact in case of an Emergency:

Relationship to Patient:

Home Phone: Work Phone: Other:

2) If unable to contact this person, please call:

Relationship to Patient:

Home Phone: Work Phone: Other:

How were you referred to us: □ Self □ Friend or Family Member □ Health Provider □ Emergency Room □Ad, Media or Outreach □ Other_________

Payment and Treatment Consent

Consent for Treatment: I hereby consent to any treatments, diagnostic tests or studies necessary by any physician or staff member of Community Health Care Systems, Inc. Release of information to third party: I hereby authorize Community Health Care Systems, Inc. to furnish information concerning my treatment, diagnosis, tests, and illness to third party payers for payment of fees incurred during treatment and diagnosis. I also understand that any portion that is not covered by insurance is my responsibility to pay. I understand that CHCS, Inc. may use any means deemed necessary to collect a debt. Payment is expected at time of service for all co-pays and deductibles.

Notice of Privacy Practices

I have reviewed the Notice of Privacy Practices provided to me by Community Health Care Systems, Inc.

Rights and Responsibilities

My Rights and Responsibilities have been made available to me by Community Health Care Systems, Inc.

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

Relationship if other than Patient:

Pharmacy: **Consent for External RX check □ Yes □ No**

Community Health Care Systems, Inc.

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:**

Marital Status: □ Married □ Partnered □ Single □ Divorced □ Widowed □ Unknown □ Legally Seperated

Language Preference □ English □ Spanish □ Other Translator Required: □ Yes

Veteran Status: □ Veteran □ Not a Veteran

Are you a migratory/agricultural worker?□ **Yes** □ **No Do you live in public housing?**□ **Yes**□ **No Are you homeless?** □ **Yes** □ **No**

Race: □ White or Caucasian □ Black or African American □ American Indian or Alaska Native □ Native Hawaiian or other Pacific Islander □ Other Race

Ethnicity: □ Hispanic □ Non-Hispanic

Who is your primary Care Giver? □**Self** □**Parent** □**Grandparent** □**Sibling** □**Spouse** □**Life Partner** □**Caregiver** □**Ward of court/Guardian** □**Unknown**

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

Sexual Orientation- Do you think of yourself as: □ Lesbian, gay or homosexual □ Straight or heterosexual □ Bisexual □ Something else, please describe_______________________________
□ Don't know □ Decline to answer, please explain why________________________________

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).

Gender Identity- What is your current gender identity? **(Check all that apply)**
□ 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

Sex at Birth- **What sex were you assigned at birth?** □ Male □ Female □ Decline to Answer, please explain why____

Please indicate your preferred provider:____

Advance Directive
□ I have an Advance Directive □ Living Will □ Durable Power of Attorney for Health Care
□ *I do not have an Advance Directive and would like to obtain more information.*

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

Relationship if other than Patient:

HIPAA/RELEASE OF INFORMATION PER PATIENT'S ASSIGNMENT

Patient Name: ______________________________ **Date of Birth:** ____________________

I, ____ (DOB) ___/___/______ have acknowledged/ received a written copy of the Community Health Care Systems, Inc (CHCS) Notice of Privacy Practices and I authorize any physician/ staff employee of CHCS to engage in any verbal or written communication to any/ all persons listed below regarding my medical history/care/ records/ appointments and/ or information pertaining to my person account/ billin history with CHCS.

NAME: ________________________________ RELATIONSHIP: ____________________

________________________________ ____________________

VOICEMAIL/ ANSWERING MACHINE

I authorize any physician/ staff employee of CHCS to leave health information on a voicemail/ answering machine at the following numbers:

PHONE NUMBER: ________________________________ LOCATION (Home, Cell, Work, etc.): ____________________

________________________________ ____________________

PATIENT UNDER AGE

If a patient is a minor (under age 18 years), please list any other person(s) over the age of 18 that is allowed to bring the minor to office visits and/ or labs. If the child is brought to an office visit by a person not listed below, written consent by parent/ guardian must be provided at date of visit.

NAME: ________________________________ RELATIONSHIP: ____________________

________________________________ ____________________

I understand that this authorization may be revoked or modified at any time on submission of my written request or that of my representative.

________________________________ ____________________

Patient/Guardian Signature **Date**

Community Health Care Systems, Inc. - Patient History Questionnaire

Name: ______________________ **Date of Birth:** ____/____/________
Date Completing Form: ______/_____/__________ **Sex:** □ **Male** □ **Female**

Allergies: Have you ever had an allergic reaction to any of the following? Check or circle all that apply.

□ Penicillin □ Codeine □ TB Shot □ Shrimp/Shell Fish □ Latex
□ Sulfa □ Iodine □ Eggs □ Adhesive Tape □ Other:__________

If yes to allergy, what happens?______________________________

Past Medical History: Have **you** had any of the following? Check or circle all that apply.

□ Seizures □ Cancer □ Diabetes □ Asthma □ Arthritis □ Stroke □ Cough
□ High Blood Pressure □ Tuberculosis □ Liver Disease □ Hepatitis □ Chest Pains □ Joint pain
□ Heart Disease □ Hemorrhoids □ Tobacco Use □ Depression/Anxiety □ Short of Breath □ Change in Bowels □ Kidney Stones
□ Pace Maker □ Kidney Disease □ Alcoholism □ Neurological Problems □ Blood Transfusion □ Skin Problems
□ Thyroid Disorder □ Stomach Problems □ Drug Use □ Bleeding Disorder □ Emphysema/Bronchitis □ Change in weight □ Sexual Transmitted Disease
□ Gout □ Anemia □ Glaucoma □ Pain □ Flu Shot □ Pneumonia shot □ Other

Have you ever had any past hospitalizations or surgeries? □ Yes □ No If yes, please list: ______________

____

Do you see other healthcare providers? □ Yes □ No If yes, please list: ______________________

____

Learning & Communication Needs: Check or circle any of the following needs, wants or beliefs that you would like to discuss or that you feel might affect your care. □ **Level of School Completed:**____________

□ Cultural Beliefs □ Emotional Issues □ Hearing/Vision Problems □ Ability/ Desire/ Motivation to Learn
□ Religious Beliefs □ Physical Limitations □ Financial Limitations □ Language Barriers
□ Other: (Please describe)______________________________

Prefer to Learn: □ Seeing/Visual □ Hearing/Verbal □ Reading/Written □ Doing/Hands On

Family Medical History:

Family Member	Living?		Number of:	If Family Member is not living, then what was the cause of death?
	Yes	No		
Father				
Mother				
Brothers				
Sisters				
Children				

Has anyone in your **family** had any of the following? Check or circle all that apply.

Illness	Relation to You
□ Cancer	
□ Heart attack / Angina	
□ Diabetes	
□ Asthma / Respiratory Problems	
□ High Blood Pressure	
□ Stroke	
□ Stomach problems / Ulcers	
□ Seizures	
□ Drug Abuse / Alcoholism	
□ Depression / Anxiety / Suicide	

Illness	Relation to You
□ Anemia / Blood disorder	
□ Kidney / Bladder Disorder	
□ Glaucoma / Eye Disorder	
□ Arthritis / Joint disease	
□ Lung Disease / Tuberculosis	
□ Sexual Disease / HIV	
□ Mental Illness	
□ Gout	
□ Thyroid Disorder	
□ Surgeries / Hospitalizations	

Patient/Guardian Signature: ______________________ **Date:** ___/___/________

EFFECTIVE DATE APRIL 14, 2003

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.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at Community Health Care Systems, Inc. may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at Community Health Care Systems, Inc. or the hospital. For example, we may disclose medical information about you to people outside Community Health Care Systems, Inc. who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run Community Health Care Systems, Inc. and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

WHO WILL FOLLOW THIS NOTICE. This notice describes our practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the practice, whether made by practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; photograph for documentation, education, or marketing purposes; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the practice's waiting room.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with Community Health Care Systems, Inc. or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact **Privacy Officer (478)864-2600.** All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

COMMUNITY HEALTH CARE SYSTEMS, INC.

PATIENT RIGHTS AND RESPONSIBILITIES

You are a valued member of your health care team! As a patient or a patient's family member, you are not just an observer in your health care experience, but are an active team member. You have certain rights and responsibilities as a health care team member.

You have the <u>RIGHT</u> to:

*Exercise these rights without regard to sex, race, creed, or cultural, economic, educational, religious background, or the source of payment for your care.

*Considerate and respectful care that respects your personal values and beliefs.

*Know the name of the physician who will be coordinating your care and the names of other physicians and other staff who will see you.

*Receive information from the physician about the illness, course of treatment and prospects for recovery in terms that you can understand.

*Receive as much information as you need about any planned treatment or procedure in order to give informed consent or to refuse a course of treatment.

*Take part in decisions regarding your medical care. To the extent permitted by law, this includes the right to refuse treatment.

*Full consideration of privacy concerning the medical care program. Occasionally, you may be seen by a student of the health sciences or a Center staff member may need to be present during your exam.

*Confidential treatment of all communications and records pertaining to health status and care.

*Reasonable responses to any reasonable requests made for service or access to care.

*Be informed by the Center staff of the ongoing health care requirements following the visit.

*Examine and receive an explanation of financial bill regardless of source of payment.

*Participation in making care decisions throughought the care process when involved in investigational studies and clinical trials. You will not be enrolled in such programs without your knowledge and consent.

*Have cultural, spiritual, psychological, and personal values respected as long as these practices do not harm others or intefere with care.

*Expect appropriate assessment and management of pain.

You have the <u>RESPONSIBILITY</u> for:

*Providing accurate and complete information concerning present complaints, past medical history, current medications, the presence of advanced directives and other information related to health status.

*Making it known whether the course of treatment and the patient's role in the course of treatment is clearly understood.

*Following the treatment plan established by the physician, including the instructions of members of the health care team related to the plan of care.

*Keeping appointments and notifying the Center in advance if unable to keep an appointment.

*Actions and the outcomes of those actions should you refuse treatment or not follow the plan of care.

*Assuring that the financial obligations of care are fulfilled as promptly as possible.

*Following Center policies and procedures affecting patient safety and conduct.

*Being considerate of the rights of other patients and Center staff.

*Being respectful of the property of self, others, and the Center.

*Discussing pain relief options with the provider.

*Complying with the pain management plan.