McKinney Medical Center, Inc.

218 Quarterman Street Waycross, GA 31501 912.287.9140 (Medical)

Patient Application

Applicant Information

Last Name:	*First Name:*	*M.I.:*
DOB:	*SSN:*	*Sex: M _____ F _____*
Marital Status:	*Are you Hispanic or Latino? Y _____ N _____*	
Race (circle one):	*Caucasian African American Asian American Indian / Alaskan*	
Sexual Preference (circle one):	*Lesbian Gay Straight Bisexual Something Else Don't Know*	
Gender Identity (circle one):	*Male Female Transgender Male Transgender Female Other*	
Current Address:		
City:	*State:*	*ZIP Code:*
Permanent Address:		
City:	*State:*	*ZIP Code:*
Telephone (home):	*Telephone (work):*	
Telephone (cell):	*Text message? Y _____ N _____*	
Email:	*Veteran?: Y _____ N _____*	
Emergency Contact:	*Relationship:*	
Telephone (home):	*Telephone (work):*	*Telephone (cell):*

Insurance Information

Please circle appropriate payer source							
Medicaid	Medicare	Insurance	WellCare	Amerigroup	PeachCare	Self Pay	Sliding Fee Scale

Name of Insurance Carrier:	*Please provide a copy of your insurance card(s)*
Name of Card Holder:	*Relationship to Patient:*

Telephone:	*DOB:*	*SSN:*

Note: In order to file insurance claims, we are required to have the Date of Birth and the Social Security Number of the policy holder.

Pharmacy Information

Pharmacy:	*City:*
Signature:	*Date:*

Employer / Income Information

Employer:	*Address:*	
City:	*State:*	*ZIP Code:*

Annual Household Income (check one): Because McKinney Medical Center is a Federally Qualified Health Center, we are required to report certain income levels on our patients. This information is for McKinney Medical Center, Inc. use only and will not be distributed or published in any way. Please complete the following information.

□ $0 - $11,170	□ $11,171 - $15,130	□ $15,131 - $19,090
□ $19,091 - $23,050	□ $23,051 - $27,010	□ $27,011 - $30,970
□ $30,971 - $34,930	□ $34,931 - $38,890	□ $38,891 and up

Number of Family Members in Household:

Homeless: Y _____ N _____	Migrant Worker: Y _____ N _____	Seasonal: Y _____ N _____
Transitional: Y _____ N _____	Street: Y _____ N _____	

NOTICE OF PRIVACY PRACTICES

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 the practice 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 the practice or the hospital. For example, we may disclose medical information about you to people outside the practice 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 the practice 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 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; 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 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 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 limited circumstances.
- **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 Special Project Officer and you must provide a reason that supports your request. We may deny your request for an amendment.
- **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 Special Project Officer.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.
- **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 of accounting of disclosures, you must submit your request in writing to the Special Project Officer.

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

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact the Special Project Officer at 912-287-0412. 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 uses 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 Special Project Officer.

_____ _____

Patient or Patient Representative *Date*

Signature on File		
I understand that Physician Assistants (PA) perform services in this facility. I understand that I have the right to see the Physician prior to receiving any prescription drug or device from the Physician Assistant.		
Printed Name:	*Signature:*	*Date:*

PATIENT FINANCIAL RESPONSIBILITY DISCLOSURE STATEMENT

Your signature below forms a binding agreement between McKinney Medical Center, Inc (MMC - the provider of medical services) and the Patient who is receiving medical services or the Responsible Party for minor patients (those patients under 18 years old). Responsible Party is the individual who is financially responsible for payment of medical bills.

All charges for services rendered are due and payable at the time of service.

COMMERCIAL INSURANCE: We have contracts with many insurance companies, and we will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason.

The person signing on behalf of the Patient as the Responsible Party must:

- Inform MMC of the current address and phone number for the patient and the responsible party.
- Present all current insurance cards prior to each office visit.
- Verify at each visit that the information is current by signing our data sheet.
- Pay any required co-pay at the time of the visit.
- Pay any additional amount owing within 30 days of receiving a statement from our office. *(When MMC receives an explanation of benefits (EOB) from your insurance company, any amounts that you need to pay will be billed to you).*

Returned Check Policy. If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the patient or the Patient's Responsible Party will be responsible for the original check amount in addition to a $30.00 Service Charge. Once notice is received of the returned check, MMC will send out a letter to notify the Responsible Party of the returned check. If a response is not made within 10 days from the letter date by the Patient or the Responsible Party, the account may be turned over to Magistrate Court where additional court fees will be added to the outstanding balance - in addition to the $30.00 Check Service Charge.

Non-Payment on Account. Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's Responsible Party, understands that MMC has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the patient's Responsible Party, understands that they are responsible for all costs of collection including, but not limited to, all court costs and Attorney fees, which will be added to the outstanding balance.

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

_____ _____

Patient Name (Please Print) *Date*

_____

Patient Signature

_____ _____

Responsible Party Name (Please Print) *Date*

_____

Responsible Party Signature

MEDICAL RELEASE

Many of our patients allow family members such as their spouse, parents or others to call and request medical/billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical/billing information released to family members you must sign this form. Signing this form will only give consent to release this information to the family members indicated below. This consent will not allow McKinney Medical Center to release any other information to these family members.

You have the right to revoke this consent in writing.

I understand that I have the right to revoke this authorization at any time, and that I must do so in writing and present my written revocation to the health information management department at MMC. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I authorize McKinney Medical Center to release my medical information to these individual(s):

1. _____ Relationship to patient: _____

2. _____ Relationship to patient: _____

3. _____ Relationship to patient: _____

Patient Name: _____

Patient Signature: _____ Date: _____