FIRST CHOICE PRIMARY CARE PATIENT INFORMATION

❑ **Check here if you need help filling out this application.**

Last Name	**First Name**	**Middle Initial**	**Maiden or Previous Name**

Street Address	**City**	**State**	**County**	**Zip Code**

Contact Number:
Home _____ Cell_____ Alternate _____

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

Preferred time to call:
❑ Morning ❑Afternoon ❑ Evening

Also notify using: ❑ Email ❑ Text Message ❑ Patient Portal

Email Address: _____

Social Security Number	**Marital Status**	**Sex** ❑ F ❑ M	**Date of Birth:** Month _____ Date _____ Year _____

Emergency Contact Information

Name
_____
Relationship to Patient_____
Address_____
City, State, Zip _____
Phone Number(s) _____
Alternate Contact:_____

Residence Situation

❑ Permanent ❑ Homeless
❑ Public Housing ❑ 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**

Please select a Primary Care Provider ❑Timothy Graves, MD ❑Gwen Riggins, FNP ❑Rhonda Rountree, FNP
❑Jennifer Evans, MD ❑Tammy Stephens, FNP ❑No Preference/First Available

Is Patient Covered by Insurance? ❑ Yes ❑ No If yes Check all that Apply ***If yes, please give current card(s) to the receptionist.**

❑ Medicare ❑ Medicaid ❑ Blue Cross ❑ CIGNA ❑ Amerigroup ❑ Workers Comp ❑ Other _____
❑Part A Only ❑ Well Care
❑Parts A & B ❑ Peach State
❑ Planning for Health Babies

Contracted Lab ❑ Lab Corp. ❑ Quest Diagnostic
***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 to Healthcare/Nutrition

1. Does lack of transportation prevent you from getting to your appointments? ❑ Yes ❑ No
2. Does your family have access to healthy food?❑ Yes ❑ No
3. Is there enough food to cover the household?❑ Yes ❑ No
4. Do you have a ❑ Speech Impediment **and/or** ❑ Hearing Impaired?

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 FCPC to provide me and/or my family with medical care. I acknowledge my responsibility to pay for services according to the policies established by FCPC. I acknowledge by signing below that I have received a copy of and read the FCPC HIPAA Privacy Policy Notice along with FCPC after hours contact.

Patient or Guardian Signature X_____ **Date** _____

_____ Initial **Arrival Time for New Patients: P**lease arrive 15 minutes prior to your scheduled appointment time. New patients who arrive after their scheduled time will be rescheduled.

_____Initial **Arrival Time for Established Patients**: All patients who arrive 5 minutes or more after their scheduled appointment time will be rescheduled or may wait to see if they can be worked in. Wait times vary and are not a guarantee you will be seen.

_____ Initial **ASSIGNMENT OF BENEFITS**: I authorize my insurance company to pay directly to First Choice Primary Care the cost allowable and otherwise payable to me under my insurance policy, applicable to the professional services rendered. I agree to pay all charges not covered by insurance payments or if I receive payment from insurance filed by your company, I will forward the payment to your office within one week of receipt of funds.

_____ Initial CONSENT **FOR TREATMENT**: I authorize First Choice Primary Care and such assistants as they may designate, to carry out diagnostic procedures if needed to better diagnose my condition and to administer such treatments and medications, as indicated. I understand that my condition may call for a consultation with another physician. If this situation occurs I authorize First Choice Primary Care to release medical information that may be needed to better provide for my medical treatment.

____ Initial **PAYMENT AGREEMENT**: The foregoing information is true to the best of my knowledge and I request First Choice Primary Care to provide my and/or my family with medical care. I acknowledge my responsibility to pay for services according to the policies established by First Choice Primary Care.

_____ Initial **Specialist Referral**: I understand that the discount program offered to eligible patients by First Choice Primary Care applies only to those services provided directly by First Choice Primary Care.

I also understand that if I am referred to a specialist, I will be responsible for the charges for those specialty services. Any payment arrangements or discounts offered by the specialist must be discussed with the specialist's office prior to my visit. While FCPC makes every effort to find low cost and accessible care, I understand that I remain responsible for payment of specialty care.

_____ Initial **Completion of Forms**: Request by patients to have forms completed should be made in advance. If you need a form completed, please furnish us with a copy of the form prior to your visit. Some lengthy forms will require a separate office visit to complete the required examination. If such a visit is required, regular office visit charges/copayments will apply. Please be advised that we cannot always complete these forms – some require the services of a specially certified person.

_____ Initial **Treatment of Chronic Pain Management and or treatment of Adult ADD/ADHD:** We do not provide narcotic Chronic Pain Management. We also do not provide medication management of adult ADD/ADHD.

Patient / or Guarantor Signature _____

FIRST CHOICE PRIMARY CARE

Consent to Obtain External Prescription History

I, _____, whose signature appears below, authorize First Choice Primary Care'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 First Choice Primary Care's providers and staff, and the information may include prescriptions I had 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	Date
Witness	Date

FIRST CHOICE PRIMARY CARE

770 Walnut Street
Macon, Georgia 31201

(478) 787-4266 Ph
(478) 787 -4199 Fax

RELEASE OF INFORMATION

I authorize First Choice Primary Care to discuss the medical treatment, results of any labs or x-rays or other procedures with the following individual(s) such as spouse or parent(Parents please note that the person that you authorize to bring in your child will have to present I.D. at the time of visit.)

_____	_____
Name	**Relationship**
_____	_____
Name	**Relationship**
_____	_____
Name	**Relationship**

This authorization will remain in effect until the following date(s): _____

_____ _____
Signature of Patient or legal representative Date

If signed by Legal Representative:

_____ _____
Relationship to Patient (authority to act on patient's behalf) Date

Purpose for Need of Disclosure: At the release of the individual

I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information might be redisclosed without obtaining my authorization.

I understand that I have the right to:

- Receive a copy of this authorization
- Refuse to sign this authorization and that treatment, payment, enrollment in a health plan or eligibility for health care benefits may not be contingent on my signing this authorization.

Revoke this authorization, except to the extent that the person(s) and or organization(s) listed above have already made in reference to this

CENTRAL GEORGIA HEALTH EXCHANGE

The next generation of patient information

Permission to Create a *Health Exchange record* and Share My Medical Information with my Healthcare Providers

We are taking part in an exciting program to improve your healthcare and make office visits easier and more convenient. To do this, all of your doctors participating in the Central Georgia Health Network (CGHN) would like your permission to share your Health Information (as defined below) through the *Central Georgia Health Exchange* electronic medical record program (*Health Exchange*). This will authorize your CGHN-participating doctors to disclose your Health Information so that it can be shared electronically with other providers of healthcare to you.

I acknowledge that I have read the information set forth below and understand the permission I am giving in this document, and have had the opportunity to have my questions answered about the *Health Exchange and this* permission form.

☐ Yes, I agree to participate in the Central Georgia Health Exchange electronic medical record

☐ No, I do not agree to participate in the Central Georgia Health Exchange electronic medical record

_____	_____	_____
Printed Name of Patient/Representative	*Signature of Patient/Representative*	*Date*

AUTHORITY OF REPRESENTATIVE:

I, _____, *do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis (Relationship to Patient):* _____

[A signed copy of this permission will be provided to the patient/representative]

This authorization will allow your CGHN-participating doctors to disclose your demographic, insurance, and medical information so that it can be shared with other providers of healthcare to you (including doctors, nurses, and other health professionals, as well as hospitals and other healthcare facilities) and CGHN, through the *Health Exchange* electronic medical record system. Only authorized healthcare providers and their contractors, and others whose job it is to maintain, secure, monitor and evaluate the operation of the information system and quality of care, would be able to access your information. The *Health Exchange* will allow your providers access to your health information more quickly and accurately than with paper charts.

By signing this authorization, I authorize all of my doctors who participate in CGHN to use and disclose my Health Information and to make such Health Information available through the *Health Exchange* to other healthcare providers who need access to my Health Information for the purposes described in this document. The Health Information may include, but is not limited to the following: Information contained in medical records; physicians' records; surgeons' records; x-rays, CAT scans, MRI films, photographs, or other radiological, nuclear medicine or radiation therapy films; pathology materials, slides or tissues; laboratory reports; genetic testing results; discharge summaries; progress notes; consultations; prescriptions; records of child abuse, spousal abuse, drug abuse and alcohol abuse; HIV/AIDS and sexually transmitted diseases diagnosis or treatment; physicals and histories; nurses' notes; patient intake forms; correspondence; social workers' records; insurance records; consents for treatment; and any other documents concerning any treatment, examination, periods of hospitalization, confinement, diagnosis or other information concerning my physical or mental condition.

Information disclosed pursuant to this permission may no longer be protected by federal health information privacy laws and may be subject to redisclosure. However, the *Health Exchange* system incorporates access controls, encryption technology and other security features designed to protect the privacy and security of your Health Information. In addition, access to the *Health Exchange* will be limited to only those users who have agreed to use the *Health Exchange* consistent with your permission. Information shared through the *Health Exchange* will be used and disclosed for the following purposes and disclosures: clinical care; obtaining reimbursement for health care services; ; for administrative functions related to the provision of and payment for care; quality monitoring and improvement; and administrative management of the *Health Exchange* and CGHN.

You can learn more about the *Central Georgia Health Exchange* by reading the information booklet,
"A Guide To The Central Georgia Health Exchange" that is available at the CGHE website (https://www.CGHE.net) or on request from your doctor's office.

I understand that I may withdraw this permission by giving written notice to Administrator, Central Georgia Heath Exchange, 777 Hemlock Street, Hospital Box 98, Macon, GA 31201. Any withdrawal of permission will be effective except to the extent action already has been taken in reliance on this permission. This permission will expire automatically if the *Central Georgia Health Exchange* program is discontinued.

I understand that my eligibility for treatment or any healthcare benefits cannot be conditioned on whether I sign this permission. However, to the extent I have refused permission, I understand that my Health Information will not be available to other providers (including The Medical Center of Central Georgia) through the *Central Georgia Health Exchange*.