NORTH GEORGIA HEALTHCARE CENTER

PO BOX 729 6120 ALABAMA HIGHWAY RINGGOLD GA 30736
PHONE: 706-935-6442 www.nghcc.com

PATIENT INFORMATION

Name (Last) _____ (First) _____ (Middle Initial) _____

Date of Birth: ___/____/_____ Soc Security Number _____Preferred Name _____

Street Address: _____City_____State_____Zip_____
Email Address: _____

Primary Phone: (home / cell) _____ Secondary Phone: (home/ cell) _____
Would you like to receive text message reminders of scheduled appointments◯ YES ◯ NO

NGHCC CAN NOW SEND AND RECEIVE TEXT MESSAGES. MESSAGE AND DATA RATES MAY APPLY DEPENDING ON YOUR CARRIER. **PLEASE NOTE TEXTING MAY NOT ALWAYS BE 100% SECURED DEPENDING ON THE MOBILE SERVICES YOU USE.** LET US KNOW HOW YOU PREFER TO BE CONTACTED. GENERIC MESSAGES WILL ONLY CONTAIN THE PATIENT'S NAME AND TO CALL NORTH GEORGIA HEALTHCARE CENTER BACK.

IS IT OK TO LEAVE A MESSAGE BY (PLACE A CHECK NEXT TO ALL THAT APPLY): **Circle Home or Cell Phone**

FOR:	**GENERIC VOICEMAIL**	**DETAILED VOICEMAIL**	**GENERIC TEXT**	**DETAILED TEXT**
APPOINTMENTS: Home or Cell Phone	_____	_____	_____	_____
FINANCIAL: Home or Cell Phone	_____	_____	_____	_____
LAB Results: Home or Cell Phone	_____	_____	_____	_____
MEDICAL: Home or Cell Phone	_____	_____	_____	_____

I AUTHORIZE NORTH GEORGIA HEALTHCARE CENTER TO CONTACT ME AND LEAVE MESSAGES IN THE MANNER THAT IS SPECIFIED ABOVE. I AM AWARE IF THIS NEEDS TO BE CHANGED, I MUST NOTIFY NGHCC IN WRITING.

- **Please provide additional contact phone number in case of emergency:**

Name of Contact: _____Phone Number: _____ Relationship _____

Race: ◯American Indian/ Alaskan Native ◯Asian ◯Black/ African American ◯Native Hawaiian ◯Other Pacific Islander ◯White ◯Other_____

Ethnicity: ◯ Non-Hispanic ◯ Hispanic or Latino ◯ Unknown ◯ Decline

Gender Identity: ◯ Male ◯ Female ◯ Transgender M to F ◯ Transgender F to M ◯ Other ◯ Decline

Employer: _____ Occupation:_____

Work Phone: _____ Extension: _____ Email: _____

Number of People in Household: _____ Public Housing ◯ YES ◯ NO / ◯ Tenant Housing / ◯ Other

Income Level of Household: ◯ $0 to $15.000 ◯ $15,001 to $25,000 ◯ $25,001 to $35,000
◯ $35,001 to $45,000 ◯ $45,001 to $55,000 ◯ $55.001 to $65,000
◯ $65,001 to $75.000 ◯ $75,001 and up

Do you have insurance? ◯ YES ◯ NO Are you interested in applying for our Sliding Scale Fee? ◯ YES ◯ NO

PRIMARY INSURANCE

NAME OF INSURED _____RELATIONSHIP_____

INSURED DATE OF BIRTH: _____ SEX: _____ SSN NUMBER: _____

INSURED EMPLOYER: _____ EMPLOYER PHONE NUMBER: _____

INSURANCE COMPANY: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

SECONDARY INSURANCE

NAME OF INSURED _____RELATIONSHIP_____

INSURED DATE OF BIRTH: _____ SEX: _____ SSN NUMBER: _____

INSURED EMPLOYER: _____ EMPLOYER PHONE NUMBER: _____

INSURANCE COMPANY: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

ASSIGNMENT, RELEASE AND CONSENT

- I hereby authorize NGHCC to furnish information to insurance carriers concerning my illness and treatment, and direct the insurer to pay, without equivocation, directly to the NGHCC, all benefits due as a result of treatment.
- I understand that I am financially responsible for all non-covered services, copays, deductibles, and/or co-insurance. I authorize and consent for NGHCC to bill me directly for recommended services performed that are not covered under the terms of my health plan.
- I authorize the physician to release any medical information required to process claims.
- A copy of this authorization will be as valid as the original.
- I consent to routine medical care rendered to me or my dependents by the attending provider/physician(s).
- I consent to treatment by a Physician's Assistant or Advanced Practice Nurse acting under the supervision of a NGHCC Physician.
- I acknowledge that I have the right to explanations about my care and treatment in a language and manner that assures I understand my treatment options.
- I understand that I have the right to refuse treatment after risks and benefits have been explained.
- I consent to voluntary Title X Family Planning services if I request them. I understand that all Title X services are voluntary and confidential. I understand that obtaining Title X services is NOT required and is NOT a requirement to obtain other services at NGHCC, Inc. I understand that I cannot be turned away for Title X services for inability to pay.
- I understand that some professional medical services such as laboratory and pathology services may be independent contractors and will bill me separately for their services.
- I acknowledge treatment may be rendered in an emergency without further consent.
- I understand that NGHCC is not liable for any act or omission in the following of provider/physician(s) instructions.

I certify that all information given by me is true.

_____ _____ _____

Print Name Signature Date of Consent

OR, IF PATIENT IS A MINOR OR LEGALLY INCOMPETENT:

(Proof of Guardianship for legally incompetent patients or non-biological/legally adopted minors must be on file with Release of Information)

NORTH GEORGIA HEALTHCARE CENTER

HIPAA PRIVACY LAWS

PATIENT ACKNOWLEDGMENT OF UNDERSTANDING

Patient's Name: _____ DOB: _____

Previous Name(s):_____

I understand the patient's health information is private and confidential. I understand that NGHCC works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand NGHCC may use and disclose the patient's personal information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission.

NGHCC possesses a detailed document called "Notice of Privacy Practices." It contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the "Notice" before signing this Acknowledgment

NGHCC may update this Acknowledgment and "Notice of Privacy Practices." I understand that if I ask, NGHCC will provide me with the most current "Notice of Privacy Practices."

Federally mandated HIPAA "Notice of Privacy Practices" is a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law and requesting communication be by specified methods of communication or alterative action.

NGHCC's established procedures help it meet its obligations to patients. These procedures may include other signature requirements, written acknowledgments, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist NGHCC by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices."

My signature below indicates that I reviewed a current copy of NGHCC's "Notice of Privacy Practices."

Signature: _____ Date: _____

_____

Relationship to patient if signed by anyone other than the patient,

(Parent, legal guardian, personal representative, etc.)

PATIENT CENTERED MEDICAL HOME

North Georgia HealthCare Center is committed to providing you with the best possible medical care based on your health needs. Our hope is that we can form a partnership to keep your whole self as healthy as possible, no matter what your current state of health.

How will a Medical Home lead to better care for me? **As your primary care provider, we will:**

- Learn about you, your family, life situation, and health goals and preferences. We will remember these and your health history every time you seek care and suggest treatments that make sense for you.
- Take care of any short-term illness, long term chronic disease, and your all-around well-being.
- Keep you up-to-date on all your vaccines and preventive screenings.
- Connect you with other members of your care team (specialists, health coaches, etc.) and coordinate your care with them as your health needs change.
- Be available to you after hours for your urgent needs.
- Notify you of test results in a timely manner.
- Communicate clearly with you so you understand your condition(s) and all your options.
- Listen to your questions and feelings. We will respond promptly to you – and your calls – in a way you understand.
- Help you make the best decisions for your care.
- Give you information about classes, support groups, or other services that can help you learn more about your condition and stay healthy.

Will my Medical Home help take care of myself? **We trust you as our patient, to:**

- Know that you are a full partner with us in your care.
- Come to each visit with any updates on medications, dietary supplements, or remedies you are using, and questions that you may have.
- Let us know when you see other health care providers so we can help coordinate the best care for you.
- Keep scheduled appointments or call to reschedule or cancel as early as possible.
- Understand your health condition: ask questions about your care and tell us when you do not understand something.
- Learn about your condition(s) and what you can do to stay as healthy as possible.
- Follow the plan that we have agreed is best for your health.
- Take medications as prescribed.
- Call if you do not receive your test results within 1 week.
- Contact us after hours only if your issue cannot wait until the next work day.

What types of services does my Medical Home provide for me?

We offer: Same day appointments / Preventative care and physicals (health risk assessments, school, sports, DOT*)* / Chronic disease management (diabetes, heart disease, arthritis, asthma and more) / Acute care for illness and injury / Well woman exams / Group visits and classes to help you lead a healthy lifestyle / 24x7 phone access to your care team / Online access to your medical records / Referrals to vetted specialists and mental health provider / Management of multi- specialty care plans including mental health

How do I access my Medical Home? For other clinical problems or medical advice, call your PCMH first.

We offer convenient same day and next day appointments, after-hours phone access and extended hours-early mornings and evenings.

MONDAY	7:00 AM – 7:00 PM
TUESDAY	7:00 AM – 7:00 PM
WEDNESDAY	7:00 AM – 7:00 PM
THURSDAY	7:00 AM – 7:00 PM
FRIDAY	7:00 AM – 7:00 PM

NORTH GEORGIA HEALTHCARE CENTER

To make an appointment, call (706) 935-6442 or log into the Patient Portal at www.nghcc.com .

How can I transfer my records to my Medical Home?

We will need your consent to obtain records from your previous primary care provider or from specialists you have seen in the past. Consent forms are available in your New Patient Packet and online on our website at www.nghcc.com .

Can I be in a Medical Home if I don't have health insurance?

We accept many insurance plans, cash patients, and in some cases you may be eligible for Sliding Fee Scale. Once you become a patient in our practice, we provide you with the same access and care regardless of your health insurance status.

We look forward to working with you as your primary care provider in your patient-centered medical home.

PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION
To INDIVIDUALS
North Georgia HealthCare Center, Inc.

Individuals Right in accordance with HIPAA Privacy Rule Regulation 45 C.F.R. §§ 164.522 – 164.528
To request that the provider: *Limit the use or disclosure of his/her PHI. *Restrict the persons to whom disclosure may be made.
*Amend PHI in his/her clinical record. * To obtain an "Accounting of Disclosures" of his/her PHI.

The patient is entitled to revoke this PHI Release of Information at ANY time for ANY reason. This revocation has to be made in writing and the date of written revocation becomes the void date for this release. A new release needs to be completed if any additions/changes to released individuals are made.

Part A: I authorize **North Georgia HealthCare Center, Inc. PO Box 729 6120 Alabama Highway Ringgold GA 30736** to release my personal health information to the following individual:

_____

NAME Relationship to Patient

Part B: I authorize the following information to be used or disclosed on my behalf:

☐ **Entire Medical Record** for time period of _____(provider progress notes, laboratory and diagnostic testing results, financial and billing information, and medical history including, as appropriate: immunization record, screening tests, allergy record, nutritional evaluation, surgical and past medical history, social and family history, and for pediatric patients a neonatal history. ENTIRE MEDICAL RECORD DOES NOT INCLUDE PSYCHOTHERAPY NOTES UNLESS RELEASED BELOW.

OR **Only limited information may be disclosed (check all applicable blocks below):**

☐ Provider Progress Notes for Diagnosis: _____
☐ Lab or Diagnostic Test Results
☐ Immunization / Allergy Records
☐ Surgical and Past Medical History
☐ Social and Family History
☐ Pharmacy Records
☐ Financial: Billing, Claims & Payment

Initial Here _____ I authorize the disclosure of information, if any, concerning testing for HIV and/or treatment for HIV or AIDS and any related conditions.
Initial Here _____ I authorize the disclosure of alcohol or drug abuse information, if any.
Initial Here _____ I authorize the release of any Behavior Health information including psychotherapy notes, diagnosis, testing and any other psychiatric information as appropriate. 45 C.F.R. § 164.508; 42 C.F.R. Part 2

Upon signing this Release of Information, you are stating that you have received a copy of the HIPAA Privacy Rule Regulation and Patients Rights.

Part C: Expiration Date: If not previously revoked, this authorization will terminate one year from the signature date below:

Signature of Patient or Representative Date

If signed by a patient representative, the Personal Representatives Authority Form must be attached this Release of Information.

CONTROLLED SUBSTANCE ACKNOWLEDGMENT

THE PRESCRIBING OF CONTROLLED MEDICATIONS IS ALWAYS AT THE DISCRETION OF THE PHYSICIAN. *NGHCC Providers have the authority to refuse prescription of controlled medications for any reason, and always when it will potentially do harm to the patient.*

In addition to signing this acknowledgement, if you are prescribed any medication listed below, you will be required to sign a Controlled Substance Contract. Our ability to provide Medical Services to others depends on our legal authority to prescribe all classes of medications. Ignoring current federal and state medical regulations governing the prescribing of controlled medication will jeopardize this legal authority. NGHCC WILL NOT MAKE ANY EXCEPTIONS TO OUR LEGAL AUTHORITY.

- *DUE TO THEIR DOCUMENTED POTENTIAL FOR ABUSE, PHYSIOLOGIC DEPENDENCE AND ADDICTION, THE FOLLOWING MEDICATIONS ARE USUALLY PRESCRIBED IN SMALL NUMBERS AND FOR SHORT PERIODS OF TIME. FOR THIS REASON, MULTI-REFILL PRESCRIPTIONS WILL NOT BE PROVIDED. HAVING BEEN ON CONTROLLED MEDICATIONS FROM A PREVIOUS PHYSICIAN IS NOT AN ACCEPTABLE REASON TO CONTINUE RECEIVING SUCH PRESCRIPTIONS. IF LONG-TERM USE IS ANTICIPATED OR DEEMED NECESSARY, REFERRAL TO A SPECIALIST IN PAIN MANAGEMENT, PSYCHIATRY, OR NEUROLOGY MAY BE REQUIRED.*

CLASS II BRAND	GENERIC
DEMEROL, MEPERGAN	MEPERDINE
DOLOPHINE	METHADONE
AMBIEN	ZOLPIDEM
PROSOM	ESTAZOLAM
DILAUDID	HYDROMORPHONE
DURAGESIC	FENTANYL
KADIAN, MsCONTIN, ORAMORPH, MSIR, ROXANOL, AVINZA	MORPHINE
PERCOCET, OXYCONTIN, ENDOCET, PERCODAN	OXYCODONE
RITAKUN, METADATE	METHYLPHENIDATE
ADDERALL, DEXEDRINE	DEXATROAMPHETAMINE
VICODIN, VICOPROFEN, LORATAB, LORCET, NORCO	HYDROCODONE

CLASS III BRAND	GENERIC
TYLENOL #2,#3,OR #4	CODEINE
FIOCET, ESGIC	BUTALBITAL

CLASS IV BRAND	GENERIC
DALMANE	FLURAZEPAM
HALCION	TRIAZOLAM
RESTORIL	TEMAZEPAM
ATIVAN	LORAZEPAM
KLONOPIN	CLONAZEPAM
LIBRIUM	CHLORDIAZEPOXIDE
SERAX	OXAZEPAM
VALIUM	DIAZEPAM
TRAXENE	CLORAZEPATE
XANAX	ALPRAZOLAM

GA SPECIAL CLASS BRAND	GENERIC
SOMA	CARISOPRODOL

I HAVE READ AND ACKNOWLEDGE THE ABOVE POLICY:

PATIENT SIGNATURE: _____DOB:_____ DATE: _____

PERSONAL MEDICAL HISTORY

Have YOU EVER had the Condition / Diagnosis below:	YES	NO	Mother, Father, OR Sibling M F S		YES	NO	Mother, Father, OR Sibling M F S
Diabetes	◯	◯	◯◯◯	Bronchitis / COPD	◯	◯	◯◯◯
Heart Attack	◯	◯	◯◯◯	**Emphysema**	◯	◯	◯◯◯
Heart Failure	◯	◯	◯◯◯	Asthma	◯	◯	◯◯◯
High Blood Pressure	◯	◯	◯◯◯	**Colon Cancer**	◯	◯	◯◯◯
Seizures	◯	◯	◯◯◯	**Breast Cancer**	◯	◯	◯◯◯
Liver Disease	◯	◯	◯◯◯	**Lung Cancer**	◯	◯	◯◯◯
Stroke	◯	◯	◯◯◯	**Prostate Cancer**	◯	◯	◯◯◯
Mental Illness	◯	◯	◯◯◯	**Ovarian Cancer**	◯	◯	◯◯◯
HIV	◯	◯	◯◯◯	**Other Cancer**	◯	◯	◯◯◯
Tuberculosis	◯	◯	◯◯◯	List Other:			
Sickle Cell	◯	◯	◯◯◯				
Kidney Problems	◯	◯	◯◯◯				
Have YOU ever had surgical procedure below:	**YES**	**NO**	**Date of Procedure:**		**YES**	**NO**	**Date of Procedure:**
Appendectomy	◯	◯		*Breast Biopsy*	◯	◯	
Tonsillectomy	◯	◯		*Hysterectomy*	◯	◯	
Cholecystectomy (Gall Bladder Removal)	◯	◯		*C-Section*	◯	◯	
Hemorrhoid Removal	◯	◯		*Colon Bypass*	◯	◯	
Other Surgeries:				*Heart Bypass*	◯	◯	

SOCIAL HISTORY

Have you ever used:	YES	NO	YEARS USED	LAST USE/ DRINK
Tobacco	◯	◯		
Smokeless Tobacco	◯	◯		
Vape / E-Cig	◯	◯		
Alcohol	◯	◯		
Liquor, Wine, Beer	◯	◯		
Other:	◯	◯		
Drugs	◯	◯		
Heroin	◯	◯		
Cocaine	◯	◯		
Methamphetamine	◯	◯		
Marijuana	◯	◯		

MARITAL STATUS	◯	SINGLE
	◯	MARRIED
	◯	WIDOWED
	◯	DIVORCED

Occupation	
SEXUAL ORIENTATION	◯ HETEROSEXUAL
	◯ HOMOSEXUAL
	◯ BISEXUAL
	◯ NOT SURE
	◯ CHOOSE NOT TO DISCLOSE