optim primary care
TATTNALL
PATIENT FOCUSED • PHYSICIAN OWNED

Glennville
1000B North Veterans Blvd,
Glennville, GA 30427
(912) 654-4599

Reidsville
125 Memorial Drive
Reidsville, GA 30453
(912) 557-3434

Cobbtown
36671 Hwy. 23
Cobbtown, GA 30420
(912) 684-2071

Date: _____

Patient Information:

Name: _____
Last First Middle

D.O.B.: _____ Place of Birth: _____SS#:_____

Sex:_____M_____F Race/Ethic Origin:_____ Marital Status: M S D W

Mailing Address: _____
City State Zip

Physical Address: _____
(If different from mailing address) City State Zip

Home Telephone: _____ Cell Telephone: _____

Email Address: _____
(Please give only if consent to receive general notices not medical information)

Employment Information:

Place of Employment: _____
City State Zip

Work Telephone: _____ Occupation: _____

Spouse/Parent Guardian Information:

Name: _____
Last First Middle

D.O.B.:_____SS#:_____Relationship:_____

Place of Employment: _____
City State Zip

Work Telephone: _____ Occupation: _____

Insurance Information:

(If you expect us to file a claim with an insurer for the patient's care, you must complete this section and provide us with a copy of the insurance card)

Primary Insurance: _____ ID#_____

Policy Holder Name: _____ D.O.B.: _____

Relationship to Patient: _____

Secondary Insurance: _____ID#: _____ Group#: _____

Policy Holder Name: _____ D.O.B.: _____

Relationship to Patient: _____

Emergency Contact:

Name: _____
Last First Relationship

Home Telephone: _____Work: _____ Cell: _____

Please read and Initial for each of the following:

_____: Do you have an Advance Directive (Living Will) Yes or No? If yes, please provide us with a copy.

_____: Workmen's Compensation: I understand my charges will be billed to my workmen's compensation carrier. I further understand that should they not pay, I'm responsible for all charges.

_____: All Co-pays and Self Pays are due at time of services unless previous arrangements made prior to office visit.

I consent to treatment necessary for the care of the above named patient. I certify that information provided by me in applying for payment under the Title XVIII of the Social Security act or by my insurance is correct. I authorize any holder of medical or other information about me to release to Medicare, Medicaid, or any insurer information needed for this or any other claim. I authorize release of my medical information to referring or other physicians and to my insurer by mail or fax. I request that payment of authorized benefits be made on behalf of me to my provider of services. I understand that I am personally financially responsible for fees associated with services not covered by my insurer. I agree to pay all responsible attorney fees and collection costs in the event of default of my payment of charges. I have read and fully understand the above consent, financial responsibility and information release statement.

_____ _____
Signature of Patient/Parent or Guardian Date

Name_____Birthday_____ Age_____Date_____

List your current medications you take:

_____
_____
_____

List any other doctors who you see and why:

_____
_____
_____

Please list any drug allergies:

_____

Do you smoke? Y N how long/how much: _____ Quit date: _____
Do you Drink Alcohol? Y N how long/how much: _____ Quit date: _____

Circle anything that you have had:

High blood pressure	Diabetes	Heart Disease	Stomach pain
Chest Pain/Tightness	Shortness of breath	Swollen ankles	Palpitations
Vertigo/Dizziness	Frequent Urination	Painful Urination	Rheumatic Fever
Hay Fever	Asthma	Bronchitis	Pneumonia
Persistent Cough	TB (Tuberculosis)	Arthritis	Heart burn/Indigestion
Nausea/Vomiting	Headache/Migraines	Ulcers	Weight loss/Weight gain
Change in bowel habits	Constipation	Diarrhea	Blood in the stool
Stroke	Heart Attack	Heart murmur	Abnormal Heart Beat
Anemia	Blood Disorder	Anxiety/Depression	Bipolar Disorder
Anorexia	Bulimia	Loss of Hearing/Vision	Insomnia
Gout	Lazy Eye	Hemorrhoids	Hepatitis or Jaundice
Ear infections	Allergies	Skin disease	Gallbladder Disease
Thyroid Disease	Kidney Disease	Kidney Stones	HIV
Herpes	Chlamydia	Gonorrhea	STD (_____)

Cancer (please describe) _____
Pain (please specific areas) _____
Do you take: (circle) Vitamins Calcium Iron
Blood Transfusion: When? _____

Woman's Health:

How old were you when your period started? _____ Menopausal, since when _____
How often do you get a period? _____ How many days do you bleed? _____
Have you ever used: The Pill or IUD or Implanon or Norplant

How many pregnancies have you ever had? _____ How many full term babies? _____
How many preterm babies? _____ How many miscarriages or abortions? _____
Have you ever had an abnormal Pap smear? Y N When_____ What was done_____
When was your last pap smear? _____

Heavy periods	Missed Periods	Hot Flashes	Trouble Getting Pregnant
Endometriosis	Fibroids	Menopause	PMS
Pelvic Inflammatory Disease (PID)		Pain during intercourse	

Name_____ Birthday _____

Do you still have your:
Uterus Y N Ovaries Y N Appendix Y N Gallbladder Y N Tonsils Y N

Have you had your tubes tied? Y N C-Section Y N Vaginal Birth Y N

List any surgeries that you have had, and when they were done.

_____

_____
Are you: Single Married Divorced Widowed Highest Level of Education? Grade /Degree_____

Do you work? Y N Where and what do you do there?
_____

Do you exercise? Y N How often?
_____

Do you want to lose any weight? Y N

Do you take any street drugs or other people's pain medications? Y N

What do you do for fun?
_____

Has anyone ever hurt you physically or sexually? Y N When was that?
_____

Did you receive counseling about that? Y N Would you like to? Y N

Check who has any of the following health problems. If unknown mark "U"

Disease	Mom	Dad	Sibling	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other
Cancer								
Heart Attack								
Stroke								
Diabetes								
Blood Pressure								
Depression								
Alcohol/Drug								

Is there anything else you want to discuss with the provider?
_____

Patient Record Disclosure

In general, the HIPAA privacy rule gives individuals the right to request on uses and disclosures of their protected health information (PHI). The individuals is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (Check all that apply):

_____ Home Telephone _____
_____ Ok to leave message with detailed information
_____ Leave message with call-back number only

_____ Work Telephone _____
_____ Ok to leave message with detailed information
_____ Leave Message with call-back number only

_____ Written Communication
_____ Ok to mail to my home address
_____ Ok to fax to this number
Fax number_____

_____ Other _____
_____

_____ _____
Patient Signature Date

_____ _____
Print Name Birth Date

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosures of and request for PHI to minimum necessary to accomplish the intended purpose. These provisions do not apply to use or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date _____ Disclose to Whom_____

Telephone _____ Description of disclosure _____

Notice of Health Information 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

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1000 B North Veterans Blvd.
P.O. Box 890
Glennville, GA 30427
(912) 654-4599
Fax: (912) 654- 4648

Reidsville
125 Memorial Drive
P.O. Box 890
Reidsville, GA 30453
(912) 557-3434
Fax: (912) 557-6760

Cobbtown
36671 Hwy. 23
P.O. Box 890
Cobbtown, GA 30420
(912) 684- 2071
Fax: (912) 684- 2074

Private Health Information (PHI) will be used for the purpose of treatment, payment, or healthcare operation only (writing prescriptions, planning menus, and mailing out bills.)

For Example:

1. Information that indentifies you will be entered in your record ad used to determine the course of treatment that should work best for you, and your health care team will use this record to document the actions they took and their own observations.

2. A bill sent to you or third party payer may include information that identifies you, your diagnosis, procedures, and supplies used.

3. The quality improvement team may use information in your health record to access the care and outcomes in your case and others like it and use this information in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

PHI may be disclosed to another Healthcare Provider for treatment and payment activities of the other Healthcare Provider. PHI may also be disclosed to another Healthcare Provider for its Healthcare Operations if:

1. The Healthcare Provider has or has had a relationship with the patient who is the subject of the PHI
2. The PHI pertains to that relationship
3. The disclosure is for the purpose of either conducting quality assessment or improvement activities, reviewing the competence or qualifications of healthcare professionals, or for detecting fraud and abuse or complying with the same.

PHI may cause used for the following: (If the patient objects to any of the uses listed below, Please cross them out.)

1. Contact patients to remind them of appointments
2. To give information about treatment alternatives of other health related benefits and services
3. Contact patients to raise funds for the hospital
4. Facility Directories
5. Research studies conducted by medical staff and allied health staff.
6. Notification of family member, other relative or close personal friend of health information relevant to that person's involvement in your care or payment related to your care.

Patient Acknowledgement of Notice of Privacy Practices

As required by the Privacy Standard of the Health Insurance
Portability and Accounting Act of 1996

(HIPPA)

I have received a copy of the Notice of Privacy Practice of Optim Healthcare on the date indicated below.

I understand that if any changes are made to this Notice of Privacy Practices, a revised copy of the Notice will be posted at the hospital.

I also understand that if I wish to receive additional copies of this Notice of Privacy Practices in the future, or if I have any questions with regard to Notice of Privacy Practices, I may contact:

Chief Privacy Officer
247 South Main Street, Reidsville, GA 30453
Telephone Number: 912- 557-1000
Fax Number: 912-557-1813

_____
Print Patient Name

_____
Signature of Patient/Parent or Guardian

_____
Date

The patient did not sign the form because: _____.

optimhealthcare

HIPAA Disclosure Authorization Form

Full Name _____
(Patient)

I hereby authorize **OPTIM HEALTHCARE** and its affiliates, its employees, and agents to use or disclose my protected health information related to and including, but not limited to, diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which may identify my name, address, and other individually identifiable health information

to _____ for the purpose of:
(Recipient)

- I understand that, at any time, this authorization may be revoked by submitting a written revocation to:

  [OPTIM PRIVACY OFFICER]
  247 South Main St
  Reidsville, GA 30453

- However, that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my health care will not be affected if I refuse to sign this form.
- I understand that information used or disclosed, pursuant to this authorization, could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

_____ _____
Date Signature of Patient or Legal Representative

_____
Authority or Relationship to Individual, if Legal Representative ***(By signing this form, I represent that I am the legal representative of the Patient identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Patient's behalf with respect to this authorization form.***

EXPIRATION DATE: This authorization will expire on _____

If an expiration date is not provided, this authorization shall be in force six (6) years from the date this authorization is executed by either the Patient/Member or appropriate legal representative.

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DISCLOSURE OF FINANCIAL RELATIONSHIPS

To assist you in making an informed decision, we hereby notify you that Optim Medical Center meets the federal definition of a physician-owned hospital, pursuant to 42 C.F.R 439.20(u). A listing of our physician owners is listed below.

Alternative sources of the services for which you have been referred to this entity are as follows:

Memorial Health
4700 Waters Avenue
Savannah, GA 31405

St. Joseph/Candler Hospital System
5353 Reynolds Street
Savannah, GA 31405

Physician Ownership Disclosures: Optim Medical Center

Don G. Aaron, MD; Michael Gaines, MD; John P. George, MD; M. Miles Goldsmith, MD;

Joseph Hegarty, MD; Bradley A. Heiges, MD; John T. Hodges, MD; Charles A. Hope II, MD;

Juha I. Jaakkola, MD; S. Mark Kamaleson, MD; Thomas Lawhorne III, MD; Donald K. McCartney, MD;

John McCormick, MD; Christopher W. Nicholson, MD; David N. Palmer, MD; Andrew Pandya, MD;

Michael D. Poole, MD; John Sarzier, MD; C. Mark Spivey, MD; George Sutherland, MD ;

Benjamin D. Sutker, MD; Edward J. Whelan, MD; James W. Wilson, MD; Kent E. Woo, MD

Grievance Protocol

I understand that it shall be the policy of Optim Medical Center that no person will be excluded, denied benefits to, or otherwise be discriminated against on the grounds of race, color, or national origin or on the basis of disability or age in admission to, participation in, or the receipt of the services and benefits under any of its programs and activities, whether carried out by Optim Medical Center or through a contractor or any other entity with which Optim Medical Center arranges to carry out its programs and activities. This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued pursuant to these statutes at Title 45 Code of Federal Regulations Parts 80, 84, and 91.

Disclosure Notice Acknowledgement

I acknowledge the above and that I have been provided the opportunity to review Optim Medical Center Notice:

X_____
Patient/ Personal Representative Signature Date

X_____
Witness Signature Date

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Agreement for Controlled Substances

Controlled substance medications (i.e. narcotics, tranquilizers, and barbiturates) are very useful, but have a high potential for misuse and are, therefore, closely controlled by the state and federal government. They are intended to relieve pain, improve function, and have the ability to work. They are not intended to simply feel good. Because my physician is prescribing such medication for me to help manage my condition:

1. **I am responsible for my controlled substance medications.** If the prescription is lost, misplaced, or stolen, or if I use it up sooner than prescribed, I understand that it will not be replaced.

2. **I will not request or accept controlled substance medication from another physician or individual while I am receiving such medication from Optim Primary Care.** Besides being illegal to do so, it may endanger my health. The only exception is if it is prescribed while I am admitted into the hospital.

3. **I will only use one pharmacy and keep the name and number on file. Refills** of controlled substance medications.

    a) **Will be made only during regular office hours** in person, as arranged by the practitioner during a scheduled office visit.
    b) **Will not be made if "I run out early."** I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.
    c) **Will not be made as an "Emergency"** such as Friday afternoon, because I suddenly realize I will run out tomorrow. **I will call at least 72 hours ahead if I need assistance with a controlled medication prescription.**

4. **I will bring in the containers of all medications prescribed by Optim Primary Care each time I see the practitioner**, even if there is no medication remaining. These will be in the **original** containers from the pharmacy for each medication.

5. I understand that if **I violate any of the above conditions,** my controlled substances prescriptions and/or treatment with Optim Primary Care may be terminated immediately. If the violation involves obtaining controlled substances from another individual, as described above, I may also be reported to my physician, medical facilities, and other authorities.

6. I understand that the **main treatment goal is to improve my ability to function and or work.** In consideration of this goal and the fact that I am given potent medication to help reach this goal, I agree to help myself by following better health habits such as exercise, weight control, and non-use of tobacco and alcohol. I understand that only through the following a healthier lifestyle can I hope to have the most successful outcome of my treatment.

7. I have no desire to harm myself or others.

8. **<u>*I agree with full informed consent to provide tissue, body fluid, or drug analysis when requested.*</u>**

9. I agree to allow Optim Primary Care to talk to my other treating practitioners, obtain records as needed, and obtain information from my pharmacy when needed.

I have been fully informed by Optim Primary Care and the staff regarding psychological dependence and physical dependence (addiction) of a controlled substance, which I understand is rare. I know that some people may develop tolerance, which is the need to increase the dose of the medications to achieve the same effect of pain control, and I do know that I will become physically dependent of some medications. Should this occur, I will stop the medication only under medical supervision or I may have withdrawal symptoms.

I have read this contract and it has been explained to me by Optim Primary Care and their staff. In addition, I fully understand the consequence of violating this contract.

_____ _____

Patient's Signature Date

_____ _____

Witness's signature Date

CONSENT TO TREAT, INSURANCE ASSIGNMENTS, FINANCIAL

AGREEMENT, AUTHORIZATION TO RELEASE INFORMATION AND

PRIVACY NOTICE ACKNOWLEDGEMENT

1. **CONSENT TO MEDICAL AND SURGICAL PROCEDURES** The undersigned consents to the medical and surgical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider. Which may include but are not limited to laboratory procedures, x-ray examination, medical or surgical treatment or procedures, anesthesia, or other services rendered the patient under the general and special instructions of the patient's physician._____ (initials)

2. **ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION**
In consideration of services rendered, I hereby transfer and assign to Optim Healthcare all rights, title and interest in any payment due to me for services described herein as provided in the above-mentioned policy or policies of insurance. The clinic may disclose all or any part of the patient's record including psychiatric, alcohol and drug abuse, family member or employer of the patient for all or part of the clinic's charge, including but not limited to medical service companies, insurance companies, workman's compensation carriers, welfare funds or the patient's employer. _____ (initials)

3. **FINANCIAL AGREEMENT** the undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she obligates himself/herself to pay the account of the clinic in accordance with the regular rates and terms of the clinic. Should the account be referred to an outside agency for collections, the undersigned should pay reasonable fees and collection expense. The undersigned certifies that he/she has read the foregoing receiving a copy thereof and is the patient or is duly authorized by the patient as patient's general agent to execute the above and accepts its terms. _____ (initials)

4. **MEDICARE / MEDICAID** Patient's certification authorization to release information and payment request. I certify that the information given to me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize that any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carries any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the clinic treating me. _____ (initials)

5. **USE OF COPIES** I permit a copy of these authorizations and assignments to be used in place of the original, which is on file at the clinic. _____ (initials)

6. **PAYMENT RESPONSIBILITY** I understand that certain insurance claims may be filed as a courtesy. However, if a claim is denied for any reason, I am responsible for payment. Insurance is considered a method of reimbursing the physician for services rendered to the patient. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charges. I understand it is my responsibility to pay any CO-PAY, DEDUCTIBLE, CO-INSURANCE, OR ANY OTHER BALANCE NOT PAID FOR BY MY INSURANCE OR THIRD PARTY PAYOR WITHIN A REASONABLE PERIOD OF TIME NOT TO EXCEED 60 DAYS. _____ (initials)

DATE: _____ PATIENT'S SIGNATURE _____

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Laboratory and Pharmacy Information

To provide quality of care and patient satisfaction, it is the patient's responsibility to ensure that we have the most current and up to date information in the system. If the information that you have provided is inaccurate, it may result in a delay in receiving your medications or a claim denial on the laboratory test performed. Please take a moment to complete this form and provide the information to the front desk. Thank you.

Patient Name:_____

In order to ensure that your labs are processed appropriately, please provide the laboratory that is required by your insurance carrier. Any laboratory tests needed will be processed through the Optim Healthcare lab unless otherwise noted on this form.

Quest_____ LabCorp_____

Other:_____

In order to ensure accurate refills of your prescriptions, please provide the pharmacy and location that you currently use for your medications:

Pharmacy:_____

Street/City:_____

Revised: 6/17/15