



CONDITIONS FOR TREATMENT

Patient Information			
Patient's Name:		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
SSN:	Birthdate:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Mailing Address:		City:	State: Zip
Phone Number:		Alternate Phone Number:	
Race: <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Other		Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non/Hispanic	
Email Address:	Employer:	Employer Phone No. ()	

IN CASE OF EMERGENCY		
Name of Friend or Relative:	Relationship to Patient:	Best contact phone#:
Do you have an Advance Directive or Living Will <input type="checkbox"/> No <input type="checkbox"/> Yes		

PATIENT PORTAL

By providing the following information, please understand that you will be sent an invitation to join the Miller County Hospital Patient Portal. After you accept your invitation, you will be allowed to view your discharge information for each visit encounter, view your labs, view your medication refills, request an appointment, and have access to other important information.

Due to security reasons, if you forget your security question, you need to call and request another invitation to the portal.

Name	
Date of Birth	
Email	
Last four digits of Social Security Number	

Signature: _____ Date: _____



**CONDITIONS FOR TREATMENT
 PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY
 PRACTICES**

As required by the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996 (HIPPA)

I have received a copy of the Notice of Privacy Practices of MILLER COUNTY HOSPITAL AND MILLER NURSING HOME 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 this Notice of Privacy Practices, I may contact:

Alisha McKinney, HIPAA Privacy Officer
 209 North Cuthbert Street
 Colquitt, GA 39837
 Phone: (229) 758-5909
 Fax: (229) 758-4242

**HIPAA RIGHT OF ACCESS FORM FOR FAMILY
 MEMBER(S)/FRIEND(S)**

If someone calls, visits, or ask about you, can we acknowledge that you are here? Yes No
 I, _____, consent for Miller County Medical Center to talk with the following people regarding my medical care. The doctor or nurses will not talk to anyone, regardless of relationship, if their name is not listed.

NAME OF PERSON TO WHOM WE COMMUNICATE	RELATIONSHIP	PHONE NUMBER

 PATIENT SIGNATURE

 DATE

 WITNESS SIGNATURE

 DATE



CONDITIONS FOR TREATMENT

MEDICAL CONSENT FOR TREATMENT

The undersigned hereby authorizes Miller County Medical Center to furnish the necessary treatments, procedures, ordered exams, x-rays, drugs, supplies, or hospital services as may be ordered or requested by the attending, consulting, or referring physician(s). The undersigned acknowledges that no guarantee or assurance has been made as to the results of treatment, surgery, or examinations in the hospital.

CONSENT TO TREAT A MINOR (IF APPLICABLE)

The patient is unable to consent because he/she is either a minor, blind, or otherwise impaired. I, therefore, consent for the patient and acknowledge the above conditions to care.

RELEASE OF INFORMATION

The undersigned hereby authorizes Miller County Medical Center, the radiologist, pathologist, and/or attending or consulting physicians, the hospital and/or physicians to release to any insurers, ambulance providers, their representatives or other third parties confidential information; including copies of medical records that relate to treatment, payment, or operational activities, related to this dated hospital.

ASSIGNMENT OF BENEFITS

In the event the undersigned and/or patient is entitled to hospital and/or physician benefits of any type whatsoever arising out of any insurance policy or any other party liable to the patient, such benefits are hereby assigned to Miller County Medical Center, and/or any physician having performed services for this patient during his/her stay at Miller County Medical Center, and the radiologist, pathologist, and/or other attending or consulting physician, for application to the patients bill. I hereby certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediators or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization to submit a claim to Medicare for payments to me

GUARANTEE OF ACCOUNT

I hereby acknowledge responsibility for this account and assume a guarantee payment of all hospital expenses incurred during the admission. I understand that I am financially responsible to the hospital for charges not paid by insurance. I understand this amount is due upon billing. Arrangements for monthly payment plans are available through the business office.

MEDICARE AND/OR MEDICAID

I certify that the information given to me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

PERSONAL VALUABLES

The hospital maintains a safe for safekeeping of money and valuables. The hospital shall not be liable for the loss or damage to any personal property, unless deposited with the hospital for safekeeping. (Examples of Personal property include dentures, jewelry, cell phone, hearing aids, glasses, money/credit cards, prosthesis devices, articles of clothing, etc.)

Acknowledgement of non-physician services

The Hospital Authority of Miller County and its affiliates utilize the services of nurse practitioners and physician assistances. A physician may not be present during all hours services are furnished to the patient.

The undersigned does acknowledge that he/she has read this acknowledgement and has freely and voluntary signed the same in their individual capacity or as the parent or legal guardian of a minor child or representative of an incapacitated adult.

Signature of Patient/Responsible party	Date	Relationship to Patient
<hr/>		
Signature of Witness	Date	



Name _____ DOB: ____-____-____ Date: ____/____/____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Depression Screen	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things?	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much?	0	1	2	3
4. Feeling tired or having little energy?	0	1	2	3
5. Poor appetite or overeating?	0	1	2	3
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down?	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching TV?	0	1	2	3
8. Moving or speaking so slowly that other people have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual?	0	1	2	3
9. Thoughts that you would be better off dead, or hurting yourself?	0	1	2	3
10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

I decline the PHQ-9 assessment at this time

PREVENTION (approximate dates)

Females	Males
Mammogram: <input type="checkbox"/> No <input type="checkbox"/> Yes: ____/____/____	Annual Prostate Exam: <input type="checkbox"/> No <input type="checkbox"/> Yes: ____/____/____
Pap Smear: <input type="checkbox"/> No <input type="checkbox"/> Yes: ____/____/____	PSA Cancer Test: <input type="checkbox"/> No <input type="checkbox"/> Yes: ____/____/____
Colonoscopy: <input type="checkbox"/> No <input type="checkbox"/> Yes: ____/____/____	Colonoscopy: <input type="checkbox"/> No <input type="checkbox"/> Yes: ____/____/____
Blood Stool Test (FIT): <input type="checkbox"/> No <input type="checkbox"/> Yes: ____/____/____	Blood Stool Test (FIT): <input type="checkbox"/> No <input type="checkbox"/> Yes: ____/____/____
Influenza Vaccination: <input type="checkbox"/> No <input type="checkbox"/> Yes: ____/____/____	Influenza Vaccination: <input type="checkbox"/> No <input type="checkbox"/> Yes: ____/____/____
Pneumonia Vaccination: <input type="checkbox"/> No <input type="checkbox"/> Yes: ____/____/____	Pneumonia Vaccination: <input type="checkbox"/> No <input type="checkbox"/> Yes: ____/____/____
Shingles Vaccination: <input type="checkbox"/> No <input type="checkbox"/> Yes: ____/____/____	Shingles Vaccination: <input type="checkbox"/> No <input type="checkbox"/> Yes: ____/____/____
Bone Density: <input type="checkbox"/> No <input type="checkbox"/> Yes: ____/____/____	Bone Density: <input type="checkbox"/> No <input type="checkbox"/> Yes: ____/____/____
Other: _____	Other: _____

Who is your primary care provider? _____

Are you a smoker? Yes ___ No ___ if yes, are you thinking about quitting or ready to quit? Yes ___ No ___

Do you have diabetes? Yes ___ No ___ When was your last Hemoglobin A1C? ____/____/____ Level _____%

Blood pressure ____/____ (>140/90 need scheduled follow up)

FALL RISK SCREEN

Do you worry about falling: <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you feel unsteady when standing or walking: <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had a fall in the past year: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes what date: ____/____/____

TELEMEDICINE INFORMED CONSENT FORM

PATIENT NAME: _____ LOCATION: _____	DATE OF BIRTH: _____	MEDICAL RECORD #: _____
PHYSICIAN NAME: _____ LOCATION: _____ CONSULTANT NAME: _____ LOCATION: _____ CONSULTANT NAME: _____ LOCATION: _____		DATE CONSENT DISCUSSED: _____

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to Miller County Medical Center providing health care services to me via telemedicine.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/audit. I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit. I understand that reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telehealth consultation, and all existing confidentiality protections under federal and Georgia state law apply to information disclosed during this telehealth visit.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting The Langdale Company at (229) 242-7450. As long as this consent is in force (has not been revoked) Miller County Medical Center may provide health care services to me via telemedicine without the need for me to sign another consent form.

I confirm that I have read and fully understand the above statements. All blank spaces have been completed prior to my signing. I have crossed out any paragraphs or words above which do not retain to me. I agree that any dispute arising from the telehealth consult will be resolved in Georgia, and that Georgia law shall apply to all disputes.

I understand there are risks and consequences from telehealth. These include, but are not limited to, the possibility, despite reasonable efforts on the part of the clinical provider, that: the transmission of my personal information could be disrupted or distorted by technical failure; the transmission of my personal information could be interrupted by unauthorized persons; and/or the electronic storage of my personal information could be accessed by unauthorized persons. In addition, I understand that telehealth-based services and care may not be as complete as face-to-face services and in some cases, symptoms and/or conditions may not improve. Finally, I understand that I may benefit from telehealth clinical services, but that results cannot be guaranteed or assured. These include but are not limited to having increased accessibility to treatment from a remote location, gaining an increase in knowledge about actively maintaining personal health and the resources available to me and improved outcomes for current symptoms and/or conditions.

I confirm that I have been advised of all the potential risks, consequences and benefits of telehealth, and that my health care practitioner has discussed with me the information from above. I have had the opportunity to ask questions about the information presented on this form and about the Telehealth Visit process.

Authorization to Release Information			
I hereby authorize Miller County Medical Center to release any medical or incidental information that may be necessary for either medical care or in processing applicants for financial benefits.			
Patient's Signature or Legal Representative		Date/Time	
Relationship to Patient	Interpreter, if Utilized	Date/Time	
Witness Signature	Date/Time	If Telephone Consent, Second Witness Signature	Date/Time



FIVESTAR Telehealth Clinic

Appointment Cancellation and No-Show Policy

Our goal at the FIVESTAR Telehealth Clinic is to provide quality primary care in a timely manner. Effective immediately, the clinic must be provided 24-hour notice if you cancel your Clinic appointment. Early cancellation will allow the clinic staff to schedule someone else in that appointment time.

Patients who fail to show for their scheduled appointment or did not notify the clinic within 24 hours of their scheduled appointment time, will be contacted by clinic staff to reschedule a new appointment time.

Appointments will not be automatically rescheduled. Patients must contact clinic staff before a new appointment will be scheduled.

Second No Show or Failure to Cancel Timely

Patients who continue to fail to show for their appointment or fail to cancel their appointment for the second time may have their clinic access privileges suspended for six months.

Participants in the Diabetes Management Program may also be temporarily removed from the program and subject to loss of other program benefits such as free diabetic medications.

How to Cancel Your Appointment

To cancel or reschedule appointments call Carsen Howell, RN at 478-234-0094 or TLC Benefit Solutions, Inc. at 877-949-0940. I acknowledge that I have read and understand the above policy.

Patient Signature

Date

Patient Printed Name

Date

Witness Signature

Date