PICKENS
Urgent Care & Primary Care

Date: _____

Student Name: _____

(Last) (First) (Middle)

Date of Birth: _____/_____/_____ Sex: _____

Address:

_____

_____

Legal Status (Circle one): Parent Guardian Current Litigation

Name: _____

(Last) (First) (Middle)

Date of Birth: _____/_____/_____ Sex: _____

E-mail: _____

Address: Same as Student or fill below

_____

_____

Primary Insurance Company: _____

Policy number: _____ Group Number: _____

Name of Primary Insurance Holder: _____

Secondary Insurance: _____

Policy number: _____ Group Number: _____

Pharmacy Name and Telephone number: _____

Emergency contact: _____

Relationship: _____Phone: _____

I authorize Pickens Urgent and Primary Care for all payments for medical services rendered to my student. I agree to be fully responsible for any service denied by my insurance company. This document shall serve as my informed consent for treatment.

Authorized Signature:

_____Date: _____

PICKENS
Urgent Care & Primary Care

744 NOAH DRIVE, SUITE 108-109, JASPER, GA 30143

706-692-0696

This notice describes our health information policy about you. Please review it carefully. If you have any questions about this notice, please contact our office.
As required by law, we may also use and disclose health information for the following types of entities, including but not limited to:
Food and Drug Administration
Public health of legal authorities charged with preventing or controlling disease, injury, or disability.

- Correctional institutions
- Worker's compensation agents
- Organ and tissue donation organizations
- Military command authorities
- Health oversight agencies
- National security agencies

Law-enforcement/legal proceedings: We may disclose health information for law enforcement purposes as required by law.
State specific requirements: Many states have requirements for reporting including population-based activities relating to improving health or reducing healthcare costs. Some states have separate privacy was it may apply additional legal requirements. If the state law preempts the federal law.
Your health information rights: Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the right to:
Inspect and copy: You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your care. Usually, this includes medical and billing records. We may deny your request to inspect and copy in certain very limited circumstances. If you were denied access to health information, you may request that the denial is reviewed. Another licensed healthcare professional chosen by the facility will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
Right to electronic copy of electronic medical records: If your PHI is maintained in electronic format, you do have the right to request that an electronic copy of your records be given to you or transmitted to another individual or entity. We will make every effort to provide access to your PHI in the form or format you request if it is readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hardcopy form.
Changes to this Notice:
We reserve the right to change this notice in the revise or change notice will be elective for information we already have about you as well as any information with the receipt in the future. The current notice will be posted in the quality elected state. In addition, each time you register for treatment or healthcare service, we will offer you a copy of the current orders in fact.
Complaints: If you believe your privacy rights have been violated, you may file a complaint with the facility by following the process outlines in the facilities patient rights documentation. You may also file a complaint with the secretary of the department of health and human services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
Other uses of health information: Other disclosures of health information not covered by this notice or the law that applies to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission in writing at any time. If you revoke your permission, we will no longer use or disclose your health information.
We may remove information that identifies you from the set of health information to protect your privacy.
We may also use indispose health information:

- To business associates, we have contracted with to perform agreed-upon services and billing for the services.
- To remind you that you have an appointment for medical care.
- To assess your satisfaction with our services.
- To tell you about possible treatment alternatives.

- To tell you about health-related benefits or services.
- To contact you as part of fundraising effort.
- For population-based activities relating to improving health and healthcare costs.
- For conducting training programs or reviewing competence of healthcare professionals.

When disclosing information, primary appointment reminders and billing/collection efforts, we may leave messages on your answering machine or voicemail.

Business associates: There are some services provided in our organization through contracts with business associates. When the services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked them to do, as well as bill you, your insurance company, or third-party payer for service and record. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Individual involved in your care or payment for your care: We make this house information about you to a friend or family member who is involved in her medical care or helps pay for your care. In addition, he may disclose health information about you to an entity in assisting in disaster relief effort so that your family can be notified about your condition, status, and location.

Research: We may disclose information to researchers when an institutional review board that has reviewed the research proposal and establish protocols to ensure of the privacy of your health information has approved the research and granted a waiver of the authorization requirements.

Future communications: We may communicate to you via email, newsletter, and mailings or other means regarding treatment options, health related information, disease management programs, wellness programs, or other community-based programs.

Organized healthcare arrangement: This facility and its medical staff members have organized and are presenting you this document is a joint notice. Information will be shared as necessary to carry out treatment, payment, and health care operations.

Amend: If you feel that the health 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. We may deny you the request for an amendment and if this occurs, you will be notified of the reason for the denial.

Right to get notice of a breach: You have the right to be notified of a breach of any of your unsecured PHI.

Accounting of disclosures: This is the list of certain disclosures we make for health information purposes other than treatment, payment, or healthcare operations where an authorization was not required.

Request restrictions: You have the right to request a restriction or limitation of the health information we use to disclose about you for treatment, payment, or healthcare operations.

You also have the right to request a limit on the health information we disclose about you to someone who involved in your care or the payment for you care like a family member or friend. For example, you could ask that we do not disclose information about your surgery you had. We are not required to agree to your request. If we do agree, we comply with your request unless the information is needed to provide you emergency treatment.

Out-of-pocket payments: If you paid out-of-pocket, or in other words, you have requested that we not go through your health plan, in full for a specific item or service, you have the right to ask that your PHI with respect to that item or service not be disclosed to a health plan for purposes of payment or healthcare operations, and we will honor that request.

Request confidential communications: You have the right to request that we communicate with you about medical matters in a certain way or certain location. For example, you can ask that we contact you at work instead of home. The facility will grant requests for confidential communications as alternative and/or via means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services rendered by the facility and related correspondence regarding payment for services. Please realize, we reserve the right to contact you by other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.

A paper copy of this notice: You have the right to a paper copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. Each time you visit a hospital, physician, or other healthcare providers, a record of your visit is made. Typically, this record contains your symptoms, examination, test results, diagnoses, treatment, a plan for future care or treatment, and billing related information. This notice applies to all the records of your care generated, whether made by personnel or agents for a clinic.

Our responsibilities: We are required by law to maintain the privacy of your health information and provide you with a description of our privacy practices. We will abide by the terms of this notice.

Uses and Disclosures-How we may use and disclose health information about you.
The following categories describe examples of the way we use and disclose health information:
For treatment: We may use health information about you to provide you treatment or services. We may disclose health information about you to doctors, nurses, technicians, health students, or other clinical personnel who are in involved in taking care of you at the clinic. We may also provide your physician, or subsequent healthcare provider, with copies of various reports that should assist him or her in treating you once you are discharged.
For payment: We may use and disclose health information about your treatment and services to bill and collect payment from you, your insurance company, or third-party payer. For example, we may need to give your insurance company information about your progress so they will pay us or reimburse you for the treatment. We may also tell your health plan about the treatment you are going to receive to determine whether a service is covered or not.
For healthcare operations: Members of the medical staff and/or quality improvement team may use your information in your health record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve. For example, we may also combine health information about many patients to evaluate the need for new services or treatment. We may disclose information to doctors, nurses, and students for educational purposes.
Marketing and any other purposes which require the sale of your information: The following uses or disclosures of your PHI will be made only with your written authorization.
1. Uses and disclosures of PHI for marketing purposes.
2. Disclosures that constitute a sale of your PHI.

Other uses and disclosures of PHI not covered by this notice or the laws that apply to use will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our privacy officer and we will no longer disclose PHI under the authorization.

Please acknowledge by signing below that you have read this notice and understand it. Thank you.

Signature: _____

Date:_____

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Minor Consent Form

I _____, parent/guardian/current litigation to

_____ (Student Name) , date of birth _____

consent to the following:

Any issues concerning divorce, custody, guardianship, probation and/or restraining orders will require all documents to be presented on first visit to verify any legal issues and/or custody of child. Copies of these documents will be kept with minor's records.

I authorize Pickens Urgent Care / Pickens Primary Care to treat and provide medical care to this patient. I also authorize the Emergency Contacts to accompany my child and I authorize Pickens Urgent Care / Pickens Primary Care to provide medical treatment to minor.

I also agree to be legally responsible for any charges minor may incur during this treatment here.

Please select your relationship to the minor.

☐ Parents

☐ Legal Guardians

☐ Current litigation

Please acknowledge by signing below that you have read this notice and understand it. Thank you.

Signature:

Date: _____