ADULT PATIENT CONSENT FORM

Thank you for allowing Whitefoord to serve you! Please complete this consent form and provide proper documentation of insurance in order to receive services.

CONSENT FOR TREATMENT

I hereby give my consent to receive comprehensive health services at Whitefoord. I further authorize any health professional working for Whitefoord to provide medical tests, procedures, and treatments that are necessary or advisable for the medical evaluation and management of my health care. This includes examinations, blood tests (including blood tests for communicable diseases such as hepatitis and HIV/AIDS when healthcare personnel have been exposed to my blood and/or body fluids), laboratory and imaging procedures, medications, infusions, nursing care and other services or treatments rendered by my physician, consulting physicians and their associates and assistants, or rendered by Whitefoord personnel under the instructions, orders or direction of such physician(s).

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign and authorize payment of all of my insurance benefits, sick benefits, Medicare benefits and injury benefits due because of liability of a third-party, payable by any party or organization directly to Whitefoord or any Whitefoord based physician, unless the account for the facility, outpatient visit or series of outpatient visits is paid in full upon discharge or upon completion of the outpatient series. If eligible for Medicare, I request Medicare services and benefits. I understand that I am responsible for any charges not covered by my insurance company.

PROMISE TO PAY

I understand that I am obligated to pay in full for any services received in accordance with the regular rates and terms of Whitefoord. If I fail to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, I agree to pay all collection agency fees, court costs and attorney's fees. I also agree that any patient or guarantor overpayments on the above Whitefoord visit may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of the overpayment.

HEALTH INFORMATION EXCHANGES (HIE)

Health information exchanges allow health care providers, including Whitefoord, to share and receive information about patients, which assists in the coordination of patient care. Whitefoord participates in a HIE that may make your health information available to other providers, health plans, and health care clearinghouses for treatment or payment purposes. Your health information may be included in the HIE. We may also make your health information available to other health exchange services that request your information for coordination of your treatment and/or payment for services rendered to you. Participation in the HIE is voluntary, and you have the right to opt out.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Whitefoord's Notice of Privacy Practices that provides information about how the Whitefoord may use and disclose my protected health information.

This health center receives HHS funding and has Federal PHS deemed status with respect to certain health or health-related claims, including medical malpractice claims, for itself and its covered individuals.

I have read and understand the above information and give permission for my care as described. *I understand that I have the right to OPT-OUT of any medical testing or treatment.* I also understand that I may obtain further information regarding the health services offered by Whitefoord by contacting (404) 373-6614.

____

Patient Name

____ _______/_______/_______

Patient/Legal Representative Signature **Date**

____ _______/_______/_______

Witness Signature **Date**

WHITEFOORD

ADULT PATIENT INFORMATION FORM

PRESENT HEALTH CONCERN/REASON FOR VISIT: ______________________________

PATIENT INFORMATION (All fields required)

Last Name: ______________________ **First Name:** ______________________

Street Address: ______________________ **County:** __________ **City:** __________ **Zip:** __________

Home Phone: ______________ **Cell Phone:** ______________ **Work Phone:** ______________

Email: ______________________

Current Primary Care Provider (PCP): ______________________ ☐ I would like to make Whitefoord my PCP

Date of Birth (mm/dd/yyyy): ______________ **Sex:** ☐ Male ☐ Female ☐ Transgender (M-to-F) ☐ Transgender (F-to-M)

Marital Status: ☐ Married ☐ Divorced ☐ Partner ☐ Single ☐ Widowed ☐ Legally Separated ☐ Unknown

Employer Name (if applicable): ______________________

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self Employed ☐ Retired ☐ Active Military ☐ Unknown

Student Status: ☐ Full Time ☐ Part Time ☐ Not a Student

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Native Hawaiian ☐ Black ☐ White **Race Cont. :** ☐ Hispanic ☐ More than one race

☐ Other: ______________ **Ethnicity:** ☐ Hispanic ☐ Non-Hispanic

Primary Language: ______________ **Do you need a translator?** ☐ Yes ☐ No

Present Housing Situation (check any that apply): ☐ Migrant ☐ Seasonal ☐ Homeless ☐ Public Housing **Are you a Veteran?** ☐ Yes ☐ No

Does this patient have an advanced directive (commonly known as a living will)? ☐ Yes ☐ No

How did you hear about Whitefoord? Please Specify: ______________________________

Emergency Contact Name: ______________________ **Emergency Contact Relation to patient:** ______________

Emergency Contact Address: ______________________________

Emergency Contact Phone Number: ______________ ☐ Cell ☐ Home ☐ Work

FINANCIAL AND INSURANCE INFORMATION (All fields required)

Who is responsible for making payment today? Who is the primary insurance holder?: ☐ Self ☐ Other

If other, Name: ______________________ Relationship to patient: ______________________

Household income information: Income Period: ☐ Hourly ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Yearly

Gross Income for Period: $ ______________ **Number of Individuals Income Supports:** ______________

Would you like us to use your income information to determine if **you qualify for our sliding fee scale discount?** ☐ Yes ☐ No

Are you covered by medical insurance?: ☐ Yes ☐ No If yes, what type of insurance?: ☐ Medicaid ☐ Private ☐ Other: __________

If Medicaid: Medicaid ID #: ______________________

If Private Insurance: Company Name: ______________________ Policy Holder Name: ______________________

Policy #: ______________________ Group #: ______________________

Do you have dental insurance? ☐ Yes ☐ No *If yes, please fill out the following:*

Company Name: ______________________ Policy Holder Name: ______________________

Policy #: ______________________ Group #: ______________________

Preferred Pharmacy Name: ______________________ **Preferred Pharmacy Phone Number:** ______________________

Preferred Pharmacy Location: ______________________________

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

**Please fill this page out if you would like to release your healthcare information to Whitefoord. **

Patient Name: ____ **Date of Birth:** _____/_____/__________

Social Security Number: _____________________________________

I request and authorize ____ **to release healthcare information of the patient named above to:**

Whitefoord Health Centers
Phone: (404) 373-6614 Fax: (404) 373-2926

This request and authorization applies to:

Healthcare information relating to the following treatment, conditions or dates:

____

☐ All healthcare information relating to the above OR

- ☐ Records only
- ☐ Lab results and X-ray/Radiology Reports
- ☐ Consultant Notes
- ☐ Other: ____

I authorize the release of STD and HIV/AIDS results whether negative or positive. I understand that Whitefoord will be notified that I must give specific written permission before disclosure of these test results to anyone. ☐ Yes ☐ No

I authorize the release of any records regarding drug, alcohol, or mental health treatment to Whitefoord. ☐ Yes ☐ No

I authorize Whitefoord to use this release for one year after completion. ☐ Yes ☐ No

I understand that I have the right to withdraw this consent at any time upon written notice to the Whitefoord Chief Medical Officer.

____ _______/_______/_______

Patient Signature **Date**

____ _______/_______/______

Parent/Guardian Signature **Date**

This Authorization Expires 1Year After It Is Signed