UNION GENERAL AFFILIATED SERVICES

Patient Data
FORM MUST BE COMPLETED IN FULL

Patient Name_____ Todays Date_____

Date of Birth_____ Social Security # _____/____/_____Gender ☐ Male ☐ Female

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Mailing Address _____
Street City State Zip

Phone Numbers Home_____ Cell_____ Work_____

Primary Phone is ☐ Home ☐ Cell ☐ Work Reminder Call Made to ☐ Home ☐ Cell ☐ Work

May we leave a personal message on your answering machine regarding any or all ongoing medical conditions? ☐ Yes ☐ No

Do we have permission to talk to another person(spouse,family member, friend) about your medical condition? ☐ Yes ☐ No

List Names_____

Email Address:_____ *(This will allow you to access our patient portal)*

Preferred Contact Method ☐ Phone ☐ Mail ☐ Email
Preferred Language ☐ English ☐ Spanish ☐Unknown ☐ Other_____
Race ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other Race ☐ Unknown ☐ Declined
Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Declined

Primary Physician_____

Guarantor Name: *(if patient is a minor)*: _____ Relation to Patient: _____
Guarantor Address: _____
Guarantor Date of Birth: _____ Guarantor Phone Number: (____)_____

Employer_____Address_____
☐ Retired, effective month/date_____ ☐ Student ☐ Unemployed

Emergency Contact
Spouse, companion, relative or friend living with you
Name & Date of Birth_____ Relationship to you_____
Phone Number_____

Insurance Information
Primary_____ Policy # _____Group #_____
Name of Insured & their relationship to you _____DOB_____

Secondary _____Policy# _____Group #_____
Name of Insured & their relationship to you _____DOB_____

Preferred Pharmacy _____ Pharmacy Phone_____
City/State_____
I authorize Union General Affiliated Services to obtain my prescription history electronically. ☐ Yes ☐ No

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY*(If patient is a minor, must be signed by parent/legal guardian)*
I certify that the above information is correct. I consent to be treated by the staff and providers of Union General Affiliated Services. I authorize payment of medical benefits to Union General Affiliated Services and its affiliates, and authorize them to release any medical information necessary to process claims. I understand that I am responsible for co-payments, deductibles, co-insurance and non-covered services.

Patient/Guarantor Signature_____Date_____

UNION GENERAL WOMEN'S HEALTH

AFFILIATE OF: UNION GENERAL HOSPITAL, INC.

123 Weaver Road | Blairsville, GA 30512 | (706) 835-2222

We are so pleased that you have chosen our office for medical care. We are committed to providing you with the highest quality of medical care. Our clinics are staffed with highly trained and friendly providers. They will be happy to see you and help assess your healthcare needs. Our Supervising Physicians will be available to oversee and supervise your care when being seen by a Nurse Practitioner or Physician's Assistant. The Primary Care and Walk-in Clinics do not personally admit patients to the hospital or provide for them while they are inpatient. We do have access through Union General Hospital and Chatuge Regional Hospital Hospitalists for these types of services. If needed, your Specialist can admit you to the hospital and manage your care while admitted.

It is important that you understand the financial policies of our office. It is equally important that you understand the terms of your insurance policy and medical coverage. Typically, you will find the insurance company's phone # on the back of your card and we encourage you to contact them with any specific questions that you may have.

If your plan is a Managed Care Plan, you must see your PCP (Primary Care Provider) prior to seeking care. In most cases you will need a referral from your PCP. If a referral cannot be obtain prior to being seen you will be asked to reschedule as most insurances will not cover services rendered without a referral and you will be held responsible for the cost.

Please be prepared to present your insurance card at the time of service. If you do not have a valid insurance card with an ID #, phone # and mailing address, we will not be able to file your medical insurance. You will be required to pay your bill in full at the time of service. **It is your responsibility to understand what is covered under your medical insurance plan.** If you have any questions about whether a service will be covered or not, we encourage you to check with your insurance company **before the service is performed.** If the reason for your visit is non-covered then you will be responsible for the bill. Example: If your child needs a sports physical, (these are not normally covered by insurance) you will be responsible for the cost. We cannot go back and alter the reason for the visit.

BILLING INFORMATION: It is essential that you provide correct and accurate information regarding your insurance, mailing address and phone #. Please update this information as often as it is necessary. We will make every effort to submit your claims to the insurance in a timely manner. If your statement is returned to us because of an invalid address, you will be turned to our collection agency and possibly dismissed as a patient. Again, please update your address, phone #, etc. as necessary.

IN NETWORK: We refer to being "in network" as the insurance companies that we have an agreement with regarding the amount of payment for certain services. This results in a discounted rate of the insured.

OUT OF NETWORK: We refer to this as the companies that we are not contracted with. If we are out of network for your insurance, we will gladly file a claim as a courtesy to you. If this payment is not made in 30 days by the insurance, it becomes your responsibility to contact your insurance company for your reimbursement if payment is denied.

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PAYMENT TERMS: Depending on your insurance policy benefits, you may be responsible for your co-pay, deductible, and in some cases co-insurance. We require that co-pays be paid at the time of service. We may require in some cases that you pay your co-insurance and/or deductible at the time of service.

PAYMENT OPTIONS: We accept cash, check, debit card, or Visa, MasterCard, American Express and Discover. An additional fee of $30.00 will be added on returned checks. We accept Medicare, GA Medicaid, Peachcare (Wellcare, Amerigroup, CareSource) and most major insurances.

OUTSTANDING BALANCES: We urge you to keep your balances current. However, if your account goes 120 days with no activity, you will be turned over to our collection agency and you will also be dismissed from the practice. You must pay off the full amount before re-instatement will be considered.

PAYMENT ARRANGEMENTS: Under special circumstances, payment arrangements can be made with our billing department.

UNINSURED PATIENTS: We offer a discounted rate for patients who are uninsured. These fees must be paid at the time of service. Failure to pay at the time of service will result in the full price being charged.

PRESCRIPTON REFILLS: We ask that you allow **48 hours** for completion of prescription refills from the time you let us know your prescription has run out. We recommend you contact your pharmacy for refills of your medications. It would be best to call one week before your prescription has run out so that there will not be a lapse in taking prescription medications. There are many medications that the insurance company requires a pre-authorization be obtained before a refill can be granted. Some medications cannot be refilled without an office visit, also required by insurance companies. It is your responsibility to ask when you need to be scheduled for an appointment to continue your medications and what your insurance requirements for obtaining refills.

LABWORK: We do draw blood in our office as a courtesy to you. It is your responsibility to know if your insurance has a preferred lab that your blood needs to go to (LabCorp, Quest, PathGroup, etc.) otherwise your specimens will be sent to Union General Hospital or Chatuge Regional Hospital.

COPIES OF MEDICAL RECORDS: We will copy your records for your personal file for $30.00. If you transfer to another physician, we will gladly forward your chart, free of charge upon receipt of your medical records release form from that physician's office.

TRANSFERRING TO ANOTHER FACILITTY: In the event you choose to transfer to another PRIMARY CARE PHYSICIAN and we release your medical records we will not re-instate you back into our facility.

NO CALL NO SHOW FOR AN APPOINTMENT: We ask as a courtesy to our providers and other patients, that you kindly give us a call 24 hours in advance if you are not able to make your appointment. If you no

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call, no show after three attempts you will be seen only on a work in basis with whichever provider is available.

FORMS: We do fill out forms for college, insurance and certain disability, etc. These can be time consuming and we do charge.

FEES AS FOLLOWS: Up to 14 min $15.00
15 min to 29 min $75.00
30 to 59 min $100.00
Over 60 min $150.00 and up

If you have any questions, or need clarification, please do not hesitate to call our billing department.

PLEASE SIGN BELOW SO WE MAY KEEP ACKNOWLEDGEMENT OF YOUR RECIEPT IN YOUR CHART.

I have read and understand the financial policy of The Clinic Affiliates of Union General Hospital and Chatuge Regional Hospital. I understand that if my insurance does not pay, for whatever reason, I will be responsible for the unpaid amount. I understand that it will be my responsibility to contact my insurance company and provide any further information regarding the unpaid claim.

I also understand the terms and policies of the other information outlined in this form.

Print Name:_____

Signature of Responsible Party:_____

Date:_____

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UNION GENERAL HOSPITAL CLINICS
Acknowledgement of Receipt
of Notice of Privacy Practices

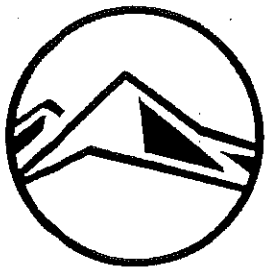
I hereby acknowledge that I received a copy of this organization's Notice of Privacy Practices.

Signed:_____ Date: _____

Print Name:_____ Telephone: _____

If not signed by the patient, please indicate relationship:

_____ Spouse or immediate family member
_____parent or guardian of minor patient
_____guardian or conservator of an incompetent patient
_____beneficiary or personal representative of deceased patient
_____ Other (describe): _____



UNION GENERAL WOMEN'S HEALTH

AFFILIATE OF: UNION GENERAL HOSPITAL, INC.

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Consent for Treatment

Union General Hospital Clinics collects health information from you and stores it in written and electronic format. This is your health information. The information is the property of Union General Hospital Clinics, but the information is accessible to you. Union General Hospital Clinics protects the privacy of your health information. The law permits Union General Hospital Clinics to use or disclose your health information for the following purposes:

Treatment: Your health information can be used or disclosed by Union General Hospital Clinics to provide you with medical treatment.
Payment: Your health information can be used or disclosed by Union General Hospital Clinics to receive payment.
Operations: Your health information can be used or disclosed by Union General Hospital Clinics operational purposes.
Personal Use: Your health information can be disclosed to you.

Union General Hospital Clinics has the right to use or disclose your health information for treatment, payment or operations once your have signed this consent form as required by State Law. Once you sign this general written consent form, it will be in effect indefinitely until you revoke your general written consent. You may revoke your general written consent at any time (in writing), except to the extent that we have already relied on it. For example, if we provide you with treatment before you revoke your general written consent, we may still share your health information with our insurance company in order to obtain payment for that treatment. To revoke your general written consent, please write to Union General Hospital Clinics: Medical Record.

I hereby authorize Union General Hospital Clinics staff:

- To access information from my health history and records,
- To administer and perform any medical examinations, treatment, or diagnostic procedures deemed necessary
- To administer vaccinations and immunizations related to my health care during my enrollment as a patient at Union General Hospital Clinics
- To provide me a medical note upon request, if appropriate (to be determined by a practitioner). This note will include my name, the date of the visit, or other information requested by myself

In addition, I understand:

- I may be asked to give specific consent for certain medical procedures
- I have the right to refuse diagnostic or treatment services, or to revoke consent
- In order to provide the best possible treatment, my provider may consult with other professionals with the Union General Hospital Clinics Staff and Chatuge Regional Hospital about issues directly related to my treatment
- Any information, which is part of my medical record at Union General Hospital Clinics, will be treated with strictest confidentiality. I understand that there are important legally mandated exceptions to confidentiality. These include:
    1) Reportable conditions, such as meningitis, tuberculosis, and specific sexually transmitted infections, which constitute public health risks;
    2) Threat of immediate danger to self or others, such as suicide or homicide;
    3) Any incidence of suspected elder or child abuse, neglect, or maltreatment; and
    4) In legal cases, the court may subpoena clinicians or clinic records.

I understand that in the event of a medical emergency, information necessary to provide appropriate treatment may be disclosed.

By signing this consent form, I am acknowledging that I have read and understood the above material regarding Union General Hospital Clinics procedures. I hereby authorize Union General Hospital Clinics and its medical staff to use and disclose my personal health information as necessary, for the purpose of obtaining medical treatment, facilitating payment for such treatments and for normal business operations.

_____ _____

Patient Signature Date

_____ _____

Signature of Parent/Legal Guardian Date

UNION GENERAL WOMEN'S HEALTH

AFFILIATE OF: UNION GENERAL HOSPITAL, INC.

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PATIENT RIGHTS & RESPONSIBILITIES

The Patient Rights and Responsibilities shall be given to every new patient and shall be permanently posted on the Clinic bulletin board.

WHEN YOU ARE SEEN BY AN EMPLOYEE OR CONTRACTOR OF THE CLINIC, YOU HAVE THE RIGHT TO:

- Be treated with consideration, respect and dignity.
- Have the confidentiality of your medical information protected, to have privacy act regulations enforced, and to have these areas of confidentiality explained to you in language you can understand.
- Have privacy during case discussion, counseling and treatment;
- Review your records in the presence of a healthcare professional;
- Know the name and qualifications of staff providing your care;
- Know your diagnosis, health problems, test results, the potential advantages and risks of treatment or procedures in language you can understand;
- Expect that all services, treatment and counseling techniques will take place with your informed consent;
- Participate in referral planning;
- Have access to the patient comment procedure;
- Refuse to participate in research;
- Have another individual present in the exam room with you, if you desire

WHEN YOU ARE SEEN BY AN EMPLOYEE OR CONTRACTOR OF THE CLINIC, YOU HAVE THE RESPONSIBILITY TO:

- Treat the staff with consideration, respect and dignity.
- Understand that your life-style does affect your health.
- Take an active part in your health care.
- Follow the agreed upon treatment plan. If you choose or are unable to follow the treatment plan, it is your responsibility to inform the Medical Provider.
- Observe facility rules and regulations that are for the safety and consideration of all patients and staff.
- Provide accurate and complete information about present complaints, past illness, hospitalizations, medications, advance directives (living wills and durable power of attorney), and other matters relating to your healthcare.
- Report whether you understand a contemplated course of action and what is expected of you.

I understand the Patient Rights and Responsibilities and have been given a copy if requested:

Patient Signature: _____ Date: _____

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Patient Confidentiality Notice

It is the office policy to NOT release confidential and/or unauthorized information by home telephone, work voicemail, or cell voicemail. Whenever returning calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Information will also NOT be left with an unauthorized person who may answer the telephone. Anyone who comes to the office on your behalf will not be able to pick up medication, prescriptions, or reports without your authorization.

I,_____, AUTHORIZE UNION GENERAL HOSPITAL CLINICS AND/OR THEIR STAFF TO LEAVE MEDICAL INFORMATION PERTAINING TO MY CARE BY THE FOLLOWING METHODS AND WILL ASSUME RESPONSIBILITY TO NOTIFY THEM WHEN EVER THIS INFORMATION CHANGES, (THIS INCLUDES LEAVING A MESSAGE TO REMIND ME OF MY APPOINTMENT).

Mark all that apply:

HOME ANSWERING MACHINE _____Yes _____ No

WORK VOICEMAIL _____ Yes _____ No

CELL PHONE _____Yes _____ No

Please list names of authorized people to leave messages/medical information, medications, prescriptions and reports with:

NAME:_____RELATIONSHIP: _____

NAME:_____RELATIONSHIP: _____

NAME:_____RELATIONSHIP: _____

SIGNATURE:_____DATE:_____

UNION GENERAL WOMEN'S HEALTH

AFFILIATE OF: UNION GENERAL HEALTH SYSTEM

Please fill out the following information.

Patient Name: Date of Birth:

Allergies:
(medication and non medication)

Allergy	Reaction

Current Medications:

Preferred pharmacy:
(Please include city ex: Ingles, Blairsville)

Kevin S. Davis, MD • Cynthia C. Mercer, MD • Kimberly Denton, MD • Benjamin Harris, MD • Christy Collins, NP-C
123 Weaver Road • Blairsville, GA 30512 • (706) 835-2222 • Fax (706) 835-2221