optim
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Patient Information:

Name:
DOB:
Sex: Female Race/Ethic Origin: _____
Mailing Address:

Home Telephone: _____
Cell Phone: _____
Employer Name & Location: _____

Spouse Name (Or parent if patient is minor): _____
Address: _____
Cell Phone: _____
Work Phone: _____

Emergency Contact (If no spouse/patent)
Phone: _____

SS#: _____
Place of Birth: _____
Marital Status: ☐M ☐S ☐D ☐W
Physical Address: (if different) _____

Work Phone: _____
Email: _____
Occupation/Position: _____
DOB: _____ SSN: _____

Employer: _____
Occupation/Position: _____

Name: _____
Alternate Phone: _____

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD OR COMPLETE THIS SECTION:

Primary Insurance: _____ ID#: _____ Group #: _____
Policyholder Name: _____ DOB: _____ Relationship: _____
Secondary Insurance: _____ ID#: _____ Group #: _____
Policyholder Name: _____ DOB: _____ Relationship: _____

☐If this is a Workmen's Compensation visit, I understand my charges will be billed to Workmen's Compensation but if they do not pay I am responsible for all charges.

☐All payments and co-payments are due at the time of service unless previous arrangements have been made prior to this visit.

☐As required by law, I have been provided with a copy of the NOTICE OF PRIVACY PRACTICE (the last three pages of this packet). I understand that if any changes are made to this policy it will be posted at the office. I can get additional copies and get any related questions answered from the Compliance & Risk Management Office at 210 East DeRenne Ave, Savannah, Georgia 31405 (877) 233-0337.

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 [[date]]

Name:
DOB:
Chart:
Age:
Date:

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Optim Primary Care- Sylvania: Release of Information

In order to allow Optim Primary Care and its employees to discuss patient information with others involved in your treatment or the payment of services rendered such as your spouse, child, relative, friend, neighbor, caretaker, etc., please provide the following information:

Patient Information

Name: **Birth Date:**

Social Security Number: **Phone Number:**

I hereby allow the Optim Primary Care physician and employees to discuss/release my medical information such as appointment reminders to verify dates and times of appointments, pick up prescriptions, lab results, care or treatment needs, etc., with the following individuals (*If you do not want to list anyone's name, please write NONE on the first row):

1. Name: _____ Phone Number: _____

Relationship to Patient: _____

2. Name: _____ Phone Number: _____

Relationship to Patient: _____

3. Name: _____ Phone Number: _____

Relationship to Patient: _____

My signature below indicates I understand the following:

I may change the names of the individuals listed above at any time. Changes must be made in writing.

Signature of Patient: Sign **Date:** [[date]]

Print Name of Patient: _____

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Name: **Date of Birth:** **Today's Date:**

PAST MEDICAL HISTORY (Please fill in blanks or write NONE):

Drug Allergies:

_____

Childhood Serious Illness: _____

Serious Injuries (when,what): _____

SURGERY (please check):

☐None ☐Appendix ☐Gall Bladder ☐Tubal Ligation ☐Hysterectomy

☐Hernia (where?) _____

☐Other: _____

ADULT ILLNESSES (check if applicable):

☐Arthritis ☐High Blood Pressure ☐Stroke ☐Heart Disease ☐Gout ☐Thyroid ☐Seizures

☐Lung Disease (asthma, emphysema) ☐Depression-Anxiety- or Other Mental Health Problem: _____

☐Liver Disease ☐Stomach or Intestinal Problems ☐Kidney Disease ☐High Cholesterol ☐Diabetes

☐Osteoporosis ☐Cancer (what kind) _____ ☐Other: _____

DATE OF LAST: Complete Physical :_____ Colonoscopy: _____ Dexa Scan :_____

Tetanus :_____ Flu Shot :_____ Pneumovac :_____

FEMALE PATIENTS: Pap Test :_____ Mammogram :_____ Birth Control Method :_____

MALE PATIENTS: Prostate Exam :_____ PSA :_____

FAMILY HISTORY (please check):

☐Heart Disease ☐High Blood Pressure ☐Diabetes ☐Thyroid Disease ☐Stomach/Intestinal Disease ☐Lung Disease (asthma, emphysema) ☐Kidney Disease ☐High Cholesterol ☐Stroke

☐Cancer (what kind) _____ ☐ Other: _____

HABIT HISTORY (please state how much used; if not used, put NONE)

Caffeine:_____ Tobacco:_____ Second-hand Smoke :_____ Alcohol:_____

CURRENT MEDICATIONS (NONE -or- SEE LIST) Any over-the-counter medications or vitamins?

Nurse Review: _____

Initial/Date: Timestamp

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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:_____

CONSENT TO OBTAIN ELECTRONIC MEDICATION HISTORY
I understand that my medication history may be obtained utilizing an electronic information exchange and that this protected health information may provide valuable information for my healthcare provider, I hereby authorize Optim Healthcare to access my medication history without limitation or exclusion as is required and/or reasonably advisable to disclose, process, retrieve, transmit, and view for the purpose of the transmission of an electronic prescription issued by a provider authorized by law to prescribe, as necessary for my care and treatment.

Date: _____ PATIENT"S SIGNATURE: _____

PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

As required by the Privacy Standard of Health Insurance Portability and Accounting Act of 1996 (HIPPA).

I have received a copy of the Notice of Privacy Practice of Optim Primary Care 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 facility.

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 the Notice of Privacy Practices, I may contact:

Compliance & Risk Management Officer
210 East De Renne Ave.
Savannah, GA 31405
1-877-223-0337 (T)

_____
Print Name

_____
Signature of Patient/Parent or Guardian

_____
Witness (OFFICE USE ONLY)

_____
Date

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

NOTICE OF PRIVACY POLICY
Effective January 1, 2009

The following is the privacy policy of Screen County Hospital ("Covered Entity") as described in the Health Insurance Portability and Accountability Act of 1996 and regulations promnlgated there under, commonly known as HIPAA. HIPAA requires Covered Entity by law to maintain the privacy of your personal health information and to provide you with notice of Covered Entity's legal duties and privacy policies with respect to your personal health information. We are required by law to abide by the terms of this Privacy Notice.

Your Personal Health Information We collect personal health information from you through treatment, payment and related healthcare operations, and/or healthcare providers or health plans, or through other means, as applicable. Your personal health information that is protected by law broadly includes any information, oral, written of recorded, that is created or received by certain health care entities, including health care providers, such as physicians and hospitals, as well as, health insurance companies or plans. The law specifically protects health information that contains data, such as your name, address, social security number, and others, that could be used to identify you as the individual patient who is associated with that health information.

Uses or Disclosures of Your Personal Health Information Generally, the may not use or disclose your personal health information without your permission. Further, once your permission has been obtained, we must use or disclose your personal health information in accordance with the specific terms of that permission. The following are the circumstances under which we are permitted by law to use or disclose your personal health information.

Without Your Consent
Without your consent, we may use or disclose your personal health information in order to provide you with services and the treatment you require or request, or to collect payment for those services, and to conduct other related health care operations otherwise permitted or required by law. Also, we are permitted to disclose your personal health information within and among our workforce in order to accomplish these same purposes. However, even with your permission, we are still required to limit such uses or disclosures to the minimal amount of personal health information that is reasonably required to provide those services or complete those activities.

> *Examples of treatment activities include:* (a) the provision, coordination, or management of health care and related services by health care providers; b) consultation between health care providers relating to a patient; or (c) the referral of a patient for health care from one health care provider to another.
>
> *Examples of payment activities include:* (a) billing and collections activities and related data processing; (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; (c) medical necessity and appropriateness of care reviews, utilization, review activities; and (d) disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.
>
> *Examples of health operations include:* (a) development of clinical guidelines; (b) contacting patients with information about treatment alternatives or communications in connection with case management or care coordination; (c) reviewing the qualifications of and training health care professionals; (d) underwriting and premium rating; (e) medical review, legal services, and auditing functions, and general administrative activities such as customer service and data analysis.

As Required By Law
We may use or disclose your personal health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law. Examples of instances in which we are required to disclose your personal belief information include: (a) public health activities including, preventing or controlling disease or other injury, public health surveillance or investigations, reporting adverse events with respect to food or dietary supplements or product defects or problems to the Food and Drug Administration, medical surveillance of the workplace or to evaluate whether the individual has a work-related illness or injury in order to comply with federal of state law, (b) disclosures regarding victims of abuse, neglect, or domestic violence including, reporting to social service or protective services agencies; (c) health oversight activities including, audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit programs; (d) judicial and administrative proceedings in response to an order of a court or administrative tribunal, a warrant, subpoena, discovery request, or other lawful process; (e) law enforcement purposes for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person or reporting crimes in emergencies, or reporting a death; (f) disclosures about decedents for purposes of cadaveric donation or organs, eyes or tissue; (g) for research purposes under certain conditions; (h) to avert a serious threat to health or safety; (i) military and veterans activities; (j) national security and intelligence activities, protective services of the President and others; (k) medical suitability determinations by entities that are components of the Department of State; (l) correctional institutions and other law enforcement custodial situations; (m) covered entities that are government programs providing public benefits, and for workers' compensation.

All Other Situations With Your Specific Authorization
Except as otherwise permitted, required, or as described above, we may not use or disclose your personal health information without your written authorization. Further, we are required to use or disclose your personal health information consistent with the terms of your authorization. You may revoke your authorization to use or disclose any personal health information at any time, except to the extent that we have taken action in reliance on such authorization or, if you provide the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

Miscellaneous Activities Notice
We may contact you to provide appointment reminders or information about treatment alternatives of other health-related and services that may be of interest to you. We may contact you to raise funds for Covered Entity.

Your Rights With Respect to Your Personal Health Information

Under HIPAA, you have certain rights with respect to your personal health information. The following is a brief overview of your rights and our duties with respect to enforcing those rights.

Right to Request Restrictions On Use Or Disclosures

You have the right to request restrictions on certain uses and disclosures of your personal health information about yourself. You may request restrictions on the following uses or disclosures: (a) to carry out treatment, payment, or healthcare operations; (b) disclosures to family members, relatives, or close personal friends of personal health information directly relevant to your care or payment related to your health care, or your location, general condition, or death; (c) instances in which you are not present or your permission cannot practicably be obtained due to your incapacity or an emergency circumstance; (d) permitting other persons to act on your behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of personal health information; or (e) disclosure to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

While we are not required to agree to any requested restriction, if we agree to a restriction, we are bound not to use or disclose your personal healthcare information in violation of such restriction, except in certain emergency situations. We will not accept a request to restrict uses or disclosures that are otherwise required by law.

Right To Inspect And Copy Your Personal Health Information

Your designated record set is a group of records we maintain that includes medical records and billing records about you, or enrollment, payment, claims adjudication, and case or medical management records systems, as applicable. You have the right of access in order to inspect and obtain a copy of your personal health information contained in your designated record set, except for: (a) psychotherapy notes; (b) information compiled in reasonable anticipation of, or for use in a civil, criminal, or administrative action or proceeding; and (c) health information maintained by us to the extent to which the provision of access to you would be prohibited by law. We may require written requests. We must provide you with access to your personal health information in the form or format requested by you, if it is readily producible in such format, or if not, a readable hard copy form or such other form or format. We may provide you with a summary of the personal health information requested, in lieu of providing access to the personal health information or may provide an explanation of the personal health information to which access has been provided, if you agree in advance to such a summary or explanation and agree to the fees imposed for such summary or explanation. We will provide you with access as requested in a timely manner, including arranging with you a convenient time and place to inspect or obtain copies of your personal health information or mailing a copy to you at your request. We will discuss the scope, format, and other aspects of your request for access as necessary to facilitate timely access. If you request a copy of your personal health information or agree to a summary or explanation of such information, we may charge a reasonable cost-based fee for copying and postage, if you request a mailing, and the costs of preparing an explanation or summary as agreed upon in advance. We reserve the right to deny you access to and copies of certain personal health information as permitted or required by law. We will reasonably attempt to accommodate any request for personal health information by, to the extent possible, giving you access to other personal health information after excluding the information as to which we have a ground to deny access. Upon denial of a request for access or request for information, information as to which we have a ground to deny access, we will provide you with a written denial specifying the legal basis for denial, a statement of your rights, and a description of how you may file a complaint with us. If we do not maintain the information that is the subject of your request for access but we know where the requested information is maintained, we will inform you of where to direct your request for access.

Right To Amend Your Personal Health Information

You have the right to request that we amend your personal health information or a record about you contained in your designated record set, for as long as the designated record set is maintained by us. We have the right to deny your request for amendment if: (a) we determine that the information or record that is the subject of the request was not created by us, unless you provide a reasonable basis to believe that the originator of the information is no longer available to act on the requested amendment (6) the information is not part of your designated record set maintained by us; (c) the information is prohibited from inspection by law; or (d) the information is accurate and complete. We may require that the denial, and a description of how you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services ("DHHS). This denial will also include a notice if you do not submit a statement of your personal health information that is the subject of the requested amendment. Copies of all requests, denials, and statements of disagreement will be included in your designated record set. If we accept your request for amendment, we will make reasonable efforts to inform and provide the amendment within a reasonable time to persons identified by you as having received personal health information of yours prior to amendment and parsons that the know have the personal health information that is the subject of the amendment and that may have relied, or could foresee ably rely, on such information to your detriment. All requests for amendment shall be sent to Privacy Officer, 210 DeRenne Avenue, Savannah, GA 31405.

Right To Receive An Accounting Of Disclosures Of Your Personal Health Information

Beginning April 14, 2003, you have the right to receive a written accounting of all disclosures of your personal health information that we have made within the six (6) year period immediately preceding the date on which the accounting is requested. You may request an accounting of disclosures for a period of time less than six (6) years from the date of the request. Such disclosures will include the date of each disclosure, the name and if known, the address of the entity or person who received the information, a brief description of the information disclosed, and a brief statement of the purpose and basis of the disclosure or, in lieu of such statement, a copy of your written authorization or written request for disclosure pertaining to such information. We are not required to provide accounting of disclosures for the following purposes: (a) treatment, payment, and healthcare operations; (b) disclosures pursuant to your authorization; (c) disclosures to you; (d) for a facility directory or to persons involved in your care; (e) for national security or intelligence purposes; (f) to correctional institutions, and (g) with respect to disclosures occurring prior to 4/14/2003. We reserve our right to temporarily suspend your right to receive an accounting of disclosures to health oversight agencies or law enforcement officials, as required by law. We will provide the first accounting to you in any twelve (12) month period without charge, but will impose a reasonable cost-based fee for responding to each subsequent request for accounting within the same twelve (12) month period. All requests for an accounting shall be sent to Privacy Officer, 210 D2Renne Ave. Savannah, GA 31405.

Complaints

You may file with us and with the Office of Regulatory Services (ORS) if you believe that your privacy rights have been violated, or if you have any other complaints or grievances. You may submit your complaint to our Compliance Officer in writing by mail, 210 DeRenne Avenue, Savannah, GA 31405, or electronically via email to our Privacy Officer at https://SOCTDHT.alertling.com, or by calling 1-877-223-0337. If you choose to file a complaint with the Office of Regulatory Services, they may be reached at 1-404-657-5726, 2 Peachtree Street, NW, Suite 33-250, Atlanta, GA 30303-3142, or you may notify the Office of the Medicare Beneficiary Ombudsman at www.Medicare.gov/Ombudsman resources.asp. A complaint must name the entity that is the subject of the complaint and describe the acts or omissions believed to be in

violation of the applicable requirements of HIPAA this Privacy Policy or any other policy. You will not be retaliated against for filing any complaint.

Amendments to this Privacy Policy

We reserve the right to revise or amend this Privacy Policy at any time. These revisions or amendments may be made effective for all personal health information we maintain even if created or received prior to the effective date of the revision of amendment. We will provide you with notice of any revisions of amendments to this Privacy Policy, or changes in the law affecting this Privacy Notice, by mail or electronically within 60 days of the effective date of such revision, amendment, or change.

On-Going Access To Privacy Policy

We will provide you with a copy of the most recent version of this Privacy Policy at any time upon your written request sent to Privacy Officer, 210 DeRenne Avenue, Savannah, GA 31405. For any other requests or for further information regarding the privacy of your personal health information, and for information regarding the filing of a complaint with us, please contact our Privacy Officer at the address or telephone number listed above.