Onsite PrimeCare, LLC

PATIENT REGISTRATION

PATIENT INFORMATION

Name: First _____ Middle _____ Last _____

Address _____

City _____ State _____ Zip Code _____

Date of Birth _____ SSN _____ Marital Status _____

Male ___ Female ___ Race _____ Ethnicity _____

Phone: Home _____ Cell _____ Work _____

Email Address _____

Reminder Method: Phone _____ Email _____ Text _____

Emergency Contact _____ Relationship _____

Emergency Contact Phone _____ Pharmacy _____

Employer _____

Employer Phone _____

Work Status: Full Time _____ Part Time _____ Unemployed _____

Referred By _____

PLESE READ AND SIGN BELOW

Any patient who fails to arrive for a scheduled appointment without cancelling the appointment in advance of appoint time is considered a “no-show”. A patient who is a “no-show” more than three (3) times will be reported to Southwire Human Resources and could be dismissed from the Practice.

This authorization is valid unless cancelled in writing. A photocopy is as valid as the original.

I authorize Onsite PrimeCare, LLC, and its service providers to contact me as needed at any telephone number associated with my account, including wireless telephone numbers or other numbers that result in charges to me, whether provided in the past, present, or future. I agree methods of contact may include pre-recorded or artificial voice messages and/or an automatic dialing system, as applicable.

CONSENT AND AUTHORIZATION FOR TREATMENT: I authorize the attending medical provider or any other members of the medical staff of Onsite PrimeCare, LLC who may be consulted by the attending physician or who may be acting in such physician's place to furnish any medical care and treatment including diagnostic procedures which the attending physician and other physicians so authorized deem necessary and appropriate for the patient's care. It is understood that Onsite PrimeCare, LLC may participate in approved health education programs which permit students to observe and participate in patient care. The undersigned agrees to allow supervised student participation in his/her care as part of the student's education.

I have read and understand all of the above and have given truthful information to the best of my knowledge.

_____ _____

Signature Date

Onsite PrimeCare, LLC

General Consent for Treatment

Patient Name: _____

Date of Birth: _____

Address: _____

_____

I consent to have treatment or physical examination/testing performed by the physician, nurse practitioner, and/or professional staff at Onsite PrimeCare, LLC. I permit the physician or nurse practitioner to treat me in ways they judge are beneficial to me. I understand this care may include tests, examinations, x-rays, and the drawing of my blood.

Consent is given by:

Patient _____ Other _____
Patient is unable to consent because: _____
I, therefore, consent for the patient.
Relationship _____

_____ _____
Signature Date

Onsite PrimeCare, LLC

PATIENT REGISTRATION

ACKNOWLEDGEMENT 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 Onsite PrimeCare, LLC on the date indicated below.

I understand if any changes are made to this Notice of Privacy Practices, a revised copy of the Notice will be posted in the office of the facility. I also understand 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:

ALLISON FLORY, PRIVACY OFFICER

P. O. Box 1273
Baxley, Georgia 31515
Phone: 229.292.4591
Email: onsiteprimecare@gmail.com

I hereby allow Onsite PrimeCare, LLC authorization to release any of my Protected Health Information/Medical Records/Appointment information to:

Name & Relationship: _____

Name & Relationship: _____

Name & Relationship: _____

Name & Relationship: _____

Name & Relationship: _____

_____ _____

Signature **Date**

_____

Printed Name

Onsite PrimeCare, LLC

PATIENT REGISTRATION

PATIENT AND CAREGIVER RIGHTS

Patients and caregivers have the right to:

- Be treated fairly, with dignity and respect, regardless of educational level, race, religion, gender, ethnicity, age, disability or source of payment.
- Have their information kept confidential; information is only released without permission when permitted or required by law.
- Have certain preferences in a provider and to choose their provider themselves, unless a legal authority has decided otherwise.
- A clear explanation of their condition and to know about their treatment choices regardless of cost or coverage by a member's benefits or plan.
- Participate in making plan of care for the patient and to request information needed to help in decision making.
- Ask for a second opinion if they wish to do so.
- Give input on the patient and caregivers' rights and responsibilities policy.
- Freely file a complaint or appeal and learn how to do so.

PATIENT AND CAREGIVER RESPONSIBILITIES

Patients and caregivers have the responsibility to:

- Treat those giving them care with dignity and respect.
- Provide information needed, including current insurance information, a current address, and a working telephone number, to help staff provide the best possible care.
- Ask questions about their condition and care plan to help them understand.
- Follow the treatment plan agreed upon with the medical provider, including using medications exactly as prescribed and explained by the doctor.
- Let their provider know when the treatment plan is not working for them or they do not understand the instructions.
- Tell their provider about visits to other providers (including the Emergency Room and Walk-On Clinic) and medication changes.
- Keep their appointments **or** call their provider as soon as they know they need to cancel a visit.
- Let their provider know about problems with paying fees and co-pays.
- Report abuse and fraud, and openly report concerns about the quality of are they receive.

My signature below shows I have been informed of my rights and responsibilities. I understand this information, agree to abide by it, and understand failing to do so may result in being dismissed as a patient of this practice.

_____ _____

Patient Signature **Date**