DIVERSITY HEALTH CENTER

Welcome to Diversity Health Center, Inc.

Diversity Health Center, Inc. (DHC) is a Federally Qualified Health Center (FQHC) serving Liberty and Long County residents. It is the mission of Diversity Health Center to provide primary, preventative and mental healthcare services through a medical home model, to improve the health status of residents in our community. Diversity Health Center offers a sliding fee scale, which allows uninsured patients to take advantage of a discount on services. DHC is excited that you chose us as your **medical home**.

If you have any questions or concerns in reference to your care, please feel free to contact your Medical Team at the phone number listed below during business hours.

Diversity Health Center maintains providers on call after hours and on weekends to evaluate urgent situations by phone. Please call (844) 877-2227 to access our on-call provider.

303 Fraser Drive Hinesville, GA 31313 (912) 877-2227 Phone (912) 877-2332 Fax **Hours**: *Monday-Thursday 8a-7p; Friday 8a-5p* ***Closed Daily 12:30-1:30p**	502 E. General Way Ste A Hinesville, GA 31313 (912) 368-1959 Phone (912) 368-1966 Fax **Hours**: *Monday-Friday 8a-5p* ***Closed Daily 12:30-1:30p**	213 N. McDonald St. Ste A Ludowici, GA 31316 (912) 545-9398 Phone (912) 545-2747 Fax **Hours**: *Monday-Thursday 8a-6p; Friday 8a-5p* ***Closed Daily 12:30-1:30p**

www.diversityhc.org

We look forward to meeting all your healthcare needs.

No patient will be turned away for inability to pay.

DIVERSITY HEALTH CENTER

DO YOU NEED ASSISTANACE WITH COMMUNICATION? YES ☐ NO ☐ PLEASE EXPLAIN:				
Date:			PCP:	
Patient's Last Name: First: Middle:			Former Name:	Is this your legal name? Yes No
Parent/Guardian's Last Name: First: Middle:				
Address:		Social Security Number:	Home Phone/ Cell Phone:	
If not, what is you legal name?	Marital Status: Circle one (Single) (Divorced) (Married)	Date of Birth:	Gender Identification: (Male) (Female) (Transgender: Male to Female) (Transgender: Female to Male)	Sexual Orientation: (Straight) (Gay/Lesbian) (Bisexual)
Mailing Address (If different):	City:		State:	Zip Code:
Employer:	Occupation:		Employer Phone Number:	
Preferred Pharmacy:	City, State:		Phone Number:	Fax Number:
How did you hear about/why did you choose clinic? Please circle one: (Doctor) (Insurance Plan) (Hospital) (Family) (Friend) (Close to home/work) (Yellow Pages) (Other):				
E-MAIL ADDRESS:				

PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST

Emergency Contact:	Relationship to Patient:	Home Phone / Cell Phone:

Race (Circle One) **White** **Black/African American** **Asian** **Native Hawaiian** **American Indian** **Other Pacific Islander** **More than one race**

Are you a Veteran? (Yes) (No)	Seasonal Worker: (Yes) (No)	Migrant Worker: (Yes) (No)	Are you homeless? (Yes) (No)	Are you Hispanic? (Yes) or (No)

If homeless, please check the option that best describes your homeless status: ☐Street ☐Doubling Up ☐Homeless Shelter ☐ Transitional Housing ☐Other

Do you have a living will? (Yes) (No)	Do you reside in public housing? (Yes) (No)	Are you disabled? (Yes) (No)

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize **DIVERSITY HEALTH CENTER, INC.,** or my insurance company to release any information required to process my claims.

_____ _____

Patient or Guardian Signature Date

Updated as of 7/2018

INCOME DETERMINATION WORKSHEET

_____ _____

Patient Name Patient Social Security Number

☐ **I do not have insurance and wish to qualify for the DHC's sliding-fee scale discount.**

☐ **I do not wish to qualify for DHC's sliding fee scale discount.** _____

Patient Initials

HOUSEHOLD INCOME AMOUNT AND FREQUENCY	**SOURCE OF HOUSEHOLD INCOME (check all that apply)**
Hourly: $ _____ X 2080 = $ _____	_____ Employment $ _____ per month
Weekly: $ _____ X 52 = $ _____	_____ Food Stamps $ _____ per month
Monthly $ _____ X 12 = $ _____	_____ Social Sec. $ _____ per month
Other: $ _____ X = $ _____	_____ SSI $ _____ per month
	_____ Child Support $ _____ per month
	_____ Other $ _____ per month

RESIDENCE: OWN: ____ RENT: ____ OTHER: _____

NUMBER OF RELATIVES IN HOUSEHOLD: _____

NAME: _____ AGE: _____ RELATIONSHIP: _____

NAME: _____ AGE: _____ RELATIONSHIP: _____

NAME: _____ AGE: _____ RELATIONSHIP: _____

NAME: _____ AGE: _____ RELATIONSHIP: _____

Proof of Income: Yes _____ No _____

Tax Return: _____ Wage Statement: _____ SS Statement: _____ Bank Statement(s): _____ Other: _____

I, _____ , have a household income of $ _____ , every

Week _____ , Month _____ ___ , Year _____, but attest that I am unable to provide proof of that income.

I attest that I have provided complete and accurate information regarding all of my household income and assets .

_____ _____ _____

PATIENT SIGNATURE / GUARDIAN SOCIAL SECURITY NUMBER DATE

WITNESS_____ _____

DIVERSITY HEALTH CENTER REPRESENTATIVE DATE

303 Fraser Drive Hinesville, GA 31313 912-877-2227 Fax: 912-877-2332
502 E. General Stewart Way Hinesville, GA 31313 912-877-2227 Fax: 912-877-2332
213 N. McDonald Street Ludowici, GA 31316 912-545-9398 Fax: 912-545-2747

CONSENT FOR MEDICAL TREATMENT

I HEREBY GIVE CONSENT TO DIVERSITY HEALTH CENTER, INC., AND ALL CLINICAL PROVIDERS, TO ADMINISTER SUCH IMMUNIZATIONS, DIAGNOSTIC, LABORATORY TESTS, OR THERAPEUTIC TREATMENT OF ILLNESSES AND/OR INJURIES, AND FOR MINOR OPERATIVE PROCEDURES AS DEEMED NECESSARY FOR ME BY A MEDICAL PRACTITIONER, AND TO REFER ME TO OTHERS AS APPROPRIATE.

I CONSENT TO VOLUNTARY TITLE X FAMILY PLANNING SERVICES IF I REQUEST THEM. I UNDERSTAND THAT ALL TITLE X SERVICES ARE VOLUNTARY AND CONFIDENTIAL. I UNDERSTAND THAT OBTAINING TITLE X SERVICES IS **NOT** A REQUIREMENT TO OBTAIN OTHER SERVICES AT DIVERSITY HEALTH CENTER, INC.. I UNDERSTAND THAT I CANNOT BE TURNED AWAY FOR TITLE X SERVICES FOR INABILITY TO PAY.

_____ _____

NAME OF PATIENT (PLEASE PRINT) **DATE**

_____ _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN **SOCIAL SECURITY NUMBER**

NOTICE OF PRIVACY PRACTICES

BY SIGNING THIS DOCUMENT, I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE JOINT NOTICE OF PRIVACY RIGHTS.

_____ _____

PATIENT SIGNATURE **PATIENT PRINTED NAME**

_____ _____

GUARDIAN SIGNATURE (IF APPLICABLE) **RELATIONSHIP TO PATIENT**

_____

DATE

OR:

REASON ACKNOWLEDGEMENT WAS NOT OBTAINED:

_____

_____ _____

WITNESS **WITNESS**

_____

DATE

DIVERSITY HEALTH CENTER

HIPAA Policy Acknowledgment

I have received a copy of Diversity Health Center's Notice of Privacy Practices Summary describing my rights and their obligations as related to the disclosure of my medical information.

_____ _____

Patient Name (Print) Date

_____

Patient or Guardian Signature

MEDICAL INFORMATION RELEASE AUTHORIZATION

We are unable to give out confidential patient information to any party over the telephone or in person without your written authorization. If you wish us to discuss your personal medical information over the telephone or in person with someone other than yourself, we ask that you complete the authorization below.

I, _____, authorize Diversity Health Center to release my protected health information (PHI) to the authorized person or persons listed below. This may include information relating to sexually transmitted diseases (STDs), acquired immunodeficiency syndrome (AIDS), and infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services and treatment for drug or alcohol abuse.

This authorization will remain in effect until revoked by me in writing.

Authorized Persons:

Name (Print) _____ Phone No. _____ Relationship _____

Name (Print) _____ Phone No. _____ Relationship _____

Name (Print) _____ Phone No. _____ Relationship _____

_____ _____

Patient or Guardian Signature Date

_____ _____

DHC Witness Date

DIVERSITY HEALTH CENTER

Patient's Rights & Responsibilities / Patient-Provider Agreement

Patient Name _____ **Date:**_____

S.S.N. _____

As a patient of Diversity Health Center, Ins. (DHC) medical clinics, I have both rights and responsibilities.

My RIGHTS are:

1. **I have the right to be respected and supported.**
2. **I have the right to be informed about and involved in all aspects of my health care.**
3. **I have the right to complete confidentiality regarding my medical records.**
4. **I have the right to care that is considerate and respectful of my personal beliefs and values.**
5. **I have the right to select or change to any qualified provider that works for DHC.**

My RESPONSIBILITIES are:

1. **I have the responsibility to report all of my significant health-related conditions that may be relevant to the ability of DHC providers to provide effective patient care.**
2. **I have the responsibility to truthfully and accurately report earnings, assets, and the insurance status (including Medicaid or Medicare eligibility) of everyone living in my household.**
3. **I have the responsibility to attend all scheduled appointments and comply with all treatments, referrals, and follow-up recommendations of my healthcare providers.**
4. **I have the responsibility to behave appropriately towards all DHC staff members.**
5. **I have the responsibility to notify my healthcare providers of any changes in my condition that may necessitate a change in my treatment plan.**
6. **I have the responsibility to contact the clinic *AT LEAST 1 (ONE) WEEK PRIOR* to running out of medication which is provided through the assistance of DHC.**
7. **I have the responsibility to supply the required documentation needed to receive medication assistance.**

DHC – *DOES NOT* TAKE WALK-INS FOR MEDICATION REFILLS!

I have read and fully understand all of my rights and responsibilities and agree to comply with the requirements of DHC.

_____ _____ _____

Signature of patient/parent/guardian ***Date*** ***DHC Witness*** ***Date***

DIVERSITY HEALTH CENTER

Diversity HIE Patient Consent & Change form

The Diversity Health Information Exchange (HIE) grants clinicians participating in your care access to your most up to date medical records. This consent is to establish if you would like to participate in the Diversity HIE.

Patient information

_____ _____

Last Name First Name

_____ _____

Date of Birth (mo/day/yr) Phone Number

Consent

___ **Participate**: I give consent to allow access to my medical records, when necessary, to participating healthcare professionals through the HIE.

___ **Opt-out**: I do not want my medical records accessed by any healthcare professional through the Diversity HIE

You can change your consent at any time by going to your healthcare provider and requesting a change.

By signing this form, I acknowledge that I have read and understand my consent options as described herein. I also understand I can change my consent at any time by completing a new HIE patient consent form and retuning it to a participating Diversity HIE healthcare professional. This consent is only to establish participation in the Diversity HIE.

_____ _____

Signature of Patient or Patient's Legal Representative Date

_____ _____

Print Name of Legal Representative (If Applicable) Relationship of Legal Representative

By signing as the patient's legal representative I certify that: the Patient's Name is accurate and correct, that I am the Parent or Legal Guardian of the Patient, and that I have authority to sign this consent on the Patient's behalf.

DIVERSITY HEALTH CENTER

NOTICE OF PRIVACY PRACTICES – SUMMARY

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

If you have any questions about this notice, please contact
the Diversity Health Center, Inc. Office
at 912-318-3971.

We may use and disclose medical, dental, and behavioral health information about you for: treatment, payment, healthcare operations, appointment reminders, treatment alternatives, health-related benefits and services, individuals involved in your care or payment for your care, research, as required by law, and to avert a serious threat to health and safety.

Special situations in which we may disclose information about you include: worker's compensation, public health risks, health oversight activities, lawsuits and disputes, law enforcement, coroners, medical examiners, funeral directors, national security and intelligence activities, protective services for the United States president and others, and inmates.

Other uses and disclosures of medical, dental and behavioral health information not covered by this notice or the laws that apply to us will be made only with your written permission.

You have the following rights regarding medical, dental, and behavioral health information we maintain about you including: the right to inspect and copy your medical, dental and behavioral health records, request an accounting of disclosures for any disclosure outside normal hospital operations, and/or request confidential communications in our dealings with you. You also have the right to receive a copy of this notice.

Changes to this notice: We may revise this notice at any time and will implement those changes for your medical, dental and behavioral health information that is in our possession as of that date. Any future medical information about you that is created or received will also be subject to the notice revisions.

Complaints: If you believe that DHC has violated your privacy rights, you may file a complaint with Diversity Health Center or the Secretary of the U.S. Department of Health and Human Services. To file a complaint with Diversity Health Center Inc., please write to: Diversity Health Center c/o Chief Executive Officer P.O. Box 1520, Hinesville, GA 31310.

Who's required to abide by this notice?

- Any healthcare professional who's authorized to enter information into your medical record.
- All departments, volunteers and units of Diversity Health Center
- All employees, staff, and other healthcare personnel who make-up the Diversity Health Center workforce
- Provider entities who have entered into an organized Health Care arrangement with Diversity Health Center

Our pledge regarding medical information

We understand that medical information about you and your health is personal; therefore, we are committed to protecting this information. This notice also will tell you about the ways in which we may use and disclose your medical information.

We're required by law to make sure that medical information that identifies you is kept private, give you this notice of our legal duties and privacy practice with respect to your medical information, and follow the terms of the notice currently in effect.

DIVERSITY HEALTH CENTER

☐ 303 Fraser Drive Hinesville, GA 31313 912-877-2227 Fax: 912-877-2332
☐ 213 N. McDonald St. Ludowici, GA 31316 912-545-9398 Fax: 912-545-2747
☐ 502 E. General Stewart Way, St. A, Hinesville, GA 31313 912-368-1959 Fax: 912-368-1966
Mailing Address for all locations: Post Office Box 1520 Hinesville, GA 31310

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:_____Date of Birth: _____

Previous Name:_____Social Security #: _____

I request and authorize:

(**your current doctor)**_____Phone #: _____

To release healthcare information of the patient named above to:

Name: _____

Address: _____

City:_____State:_____Zip Code:_____

This request and authorization applies to:

☐ Healthcare information relating to the treatment, condition, labs, consults, diagnostics information etc.
☐ All healthcare information
☐ Other: _____

Definition: Sexually transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome) and gonorrhea.

☐ Yes ☐ No

I authorize the release of STD results, HIV/AIDS testing whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above 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 drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature:_____Date Signed:_____

DIVERSITY HEALTH CENTER

Notice of Privacy Practices

PARTIES WHO MUST **ADHERE** TO THESE PRINICPLES

- Any employee or volunteer of Diversity Health Center (DHC)
- Any healthcare professional authorized to enter information into your medical record
- Any provider or entity that has entered into an Organized Health Care Agreement with DHC
- Any health care professional authorized to access your medical record

WE LEGALLY MUST:

- Ensure that any medical information that identifies you is kept private
- Provide you with notice of our legal duties and privacy practices related to medical information concerning you
- Perform according to the terms of the privacy notice that is currently in effect

OUR PROMISE:

We are committed to protect the confidentiality of the medical information about you and use that information only to care for you properly and share that information only in the manner we describe in this document.

WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU IN THE FOLLOWING MANNERS:

- *To provide you with medical treatment and medical services* We may use and share this information with doctors, nurses, technicians, medical students and other healthcare personnel involved in taking care of you both within and outside our facilities
- *To ensure that payment for treatment and services may be properly billed to you and payment received from you* this may involved the sharing of your medical information and your demographic information with insurance providers or other healthcare providers that may be directly involved in your treatment or treatment plan. We also may share your medical information with individuals who may help with the payment for your care.
- *To effectively manage our facilities and ensure a consistent quality of care* this may include the evaluation of our staff, the education of our staff or the determination of need for additional services. We may also combine your medical information with that of other patients for similar purposes.
- *To remind you of appointments for treatment at our facilities or with others that have been arranged to be involved with your treatment*
- *To provide you with recommendations regarding possible treatment options and to tell you about health benefits or services that may be of interest to you*
- *To inform your family or friends of your medical condition or to disclose your medical information to disaster relief organizations so that your family may be informed regarding your condition and location* You may notify us if you do not wish for your name or condition to be released to family or friends.
- *To provide you with recommendations regarding possible treatment options and to tell you about health benefits or services that may be of interest to you*
- *To comply with local, state or federal laws*
- *To prevent a serious threat to your health and safety or to the health and safety of another person or the public*

DIVERSITY HEALTH CENTER

Notice of Privacy Practices

- *To facilitate your pre-acknowledged or authorized donation of organs or tissue*
- *To comply with military regulations if you are a member of the armed services*
- *To comply with Workers' Compensation or similar programs that provide benefits for work- related illness or injuries*
- *To facilitate public health activities such as:*
    - the report of births and deaths
    - the prevention of disease or injury
    - the report of elder or child abuse or neglect or domestic violence
    - the report of medication problems or reactions
    - the notification of product recalls
    - the notification of others who may have been exposed to a disease or condition or may be at risk for contracting or spreading such a disease or condition
- *To respond to a court or administrative order but only if efforts have been made to contact you regarding the request or to secure an order of protection regarding the information requested*
- *To law enforcement agencies to either report a crime, to assist in locating a suspect or to locate a victim or material witness*
- *To coroners, medical examiners or funeral directors to either determine a cause of death or to facilitate the discharge of their duties*
- *To authorized federal officials to support national security or intelligence activities*
- *To facilitate the protection of the president of the United States, other authorized persons, or foreign heads of state.*
- *To facilitate your treatment, protect your health, safety and security or the health and safety and security of others if you are in the custody of a law enforcement official or an inmate in a correctional facility*

*Other uses and disclosure of medical information not covered by this notice or by law require your advance, written permission, which may be revoked by you in writing at any **time.***

YOU HAVE RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

- You have the right to inspect and copy medical information used in decision regarding your care with the exception that psychotherapy notes will be excluded. If your request a copy of this information, the request must be in writing, made to the Chief Executive Officer of DHC and you will be charged a fee for copying the information. In very special circumstances we may deny your request to inspect and copy your medical information. In the event that you dispute this denial, DHC will select another licensed healthcare professional to review your dispute and DHC will comply with the results of that review.
- You have the right to request that we amend your medical information if you feel it is incomplete or inaccurate and such a request must be made in writing to the Chief Executive Officer of DHC. We may deny your request if you are asking for the amendment of
    - Accurate and complete information
    - Information that was not created by DHC
    - Information that is not either retained by DHC or that is not information which you would be permitted to inspect and copy
- You have the right to request a list of disclosures that we have made of your medical information, excluding

disclosures we have made related to treatment, payment or clinic operations as disclosed in this document. We will keep these disclosures for a period of six year. Such a request should be made in writing to the Chief Executive Officer of DHC.

Notice of Privacy Practices

- You have the right to request a list of disclosures that we have made of your medical information, excluding disclosures we have made related to treatment, payment or clinic operations as disclosed in this document. We will keep these disclosures for a period of six year. Such a request should be made in writing to the Chief Executive Officer of DHC.
- You have the right to request restrictions or limitations on the medical information we use or disclose about you but we may disagree with those restrictions. We will, however, comply with your request if that request is made in writing describing the information you want to limit, the limits you want to place on the use or disclosure of information and to which parties you want those limitations to apply.
- You have the right to request that we contact you in a certain way or at a certain location in order to protect your privacy.
- You have the right to a paper copy of this notice.

We may revise this notice at any time and will implement those changes for your medical information that is in our possession as of that date. Any future medical information about you that is created or received will also be subject to the notice revisions.

If you believe that DHC has violated your privacy rights, you may file a complaint with Diversity Health Center or the Secretary of the U.S. Department of Health and Human Services. To file a complaint with Diversity Health Center, please write to:

Chief Executive Officer
Diversity Health Center
P.O. Box 1520
Hinesville, GA 31310