OLE TOWN MED 2580 Jackson Avenue West Suite 44, Oxford, MS 38655
oletownmed@gmail.com 662.234.9112

PATIENT INFORMATION

Date:_____

Last Name_____ First_____ Middle Initial_____

Social Security#_____ DOB_____ Age_____ Sex_____

Mailing Address_____Apt #_____

City_____ State_____ Zip_____

Phone # Home (___)_____ Cell (___)_____ Work (___)_____

Email:_____

Physical Address_____ City_____ State_____ Zip_____

Marital Status: ___Single ___Married ___Divorced ___Widowed ___Separated

Employment: ___Full-time ___Part-time ___Retired Other_____

Employer_____ Occupation_____

Student: ___ Full-time ___ Part-time____ School Name_____

<u>Emergency Contact Information:</u>

Name_____ Relationship_____

Phone #_____

Is this accident related? ___ MVA ___ Worker's Compensation ___Other

Date of accident_____

Description of accident_____

_____

_____

*****RELEASE OF PERSONAL HEALTH INFORMATION*****

Who may we discuss your health information with?_____

_____

Phone #(___)_____ Can we leave a message on your phone/cell? _____

Everything stated above is true and complete to the best of my knowledge and I agree to notify you of any changes

PHARMACY NAME _____ City_____ State _____

PRIMARY CARE PHYSICIAN NAME_____ City_____ State_____

_____ _____

Signature of patient or guardian Date

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INSURANCE INFORMATION

PERSON RESPONSIBLE FOR BILL

NAME:_____DATE OF BIRTH: _____/_____/_____

SSN: _____

ADDRESS:_____

_____ PHONE #: (_____) _____-_____

RELATIONSHIP TO PATIENT: _____

POLICY HOLDER INFORMATION:

Subscriber's Name_____

Subscriber's Address_____

_____

SS#_____

DOB_____

Employer_____

Work #_____

Policy #_____

Group #_____

SECONDARY INSURANCE:

Subscriber's Name_____

Subscriber's Address_____

_____

SS#_____

DOB_____

Employer_____

Work #_____

Policy #_____

Group #_____

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CONSENT FOR EVALUATION AND TREATMENT

The undersigned hereby consents to whatever evaluation or treatment the assigned healthcare provider may deem necessary to the patient named below.

_____ _____
Patient, Parent, Legal Guardian, or Authorized Representative Signature Date

Insurance Agreement

I hereby authorize my insurance benefits to be paid directly to Ole Town Med. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

_____ _____
Patient, Parent, Legal Guardian, or Authorized Representative Signature Date

For Medicare Patients Only

Medicare Part B Signature Authorization For Lifetime

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to be released to the Social Security Administration or its intermediaries or carriers of any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment.

_____ _____
Patient, Parent, Legal Guardian, or Authorized Representative Signature Date

_____ _____
Print Name Medicare Part B Number

Authorization Of Medical Records

Do you authorize Ole Town Med to obtain & release medical records to your Primary Care doctor?
( ) yes ( ) no
Do you authorize Ole Town Med to obtain & release medical records to your Referring doctor?
( ) yes ( ) no

_____ _____
Patient, Parent, Legal Guardian, or Authorized Representative Signature Date

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Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by either a copy of my medical records or a summary or narrative of my protected health information to the physician/person/facility/entity listed below.

Patient Name: _____ Date of Birth:_____

Release my protected health information to the following physician/person/facility/entity and/or those directly associated in my medical care:

Name: **Ole Town Medical Clinic**
Address: **2580 Jackson Avenue West**
City, State, Zip Code: **Oxford, MS, 38655**

Requesting Medical Records from:

Name: _____

Address:_____

City, State, Zip Code:_____

Information Requested:_____

_____ _____
Patient Name Signature of Patient or Personal Representative

_____
Date

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INFORMED CONSENT FOR TELEMEDICINE SERVICES

Patient Name: _____ DOB:_____

Location of Patient _____

Practitioner Name _____Location of Practitioner: _____

Consultant Name: _____ Location of Consultant_____

TELEHEALTH SERVICES: I understand that telehealth services provided will be done through a two-way audio/video link with a healthcare provider. I understand that a Nurse Practitioner will examine me with the assistance of trained personnel. I understand that this examination will be done through a two-way audio/video link and that I can ask the exam and/or video conference be stopped at any time. I understand there are potential risks including, but limited to, interruption and/or disconnection of the audio/video link, a picture not clear enough for the needs of the consultation, and electronic tampering.

I understand that the laws that protect my privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/audit.

I understand that I will be responsible for any copayments or coinsurance that apply to my telemedicine visit.

I understand that I have the right to withhold my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing by contact Ole Town Med at telephone number 662.234.9112. As long as this consent is in force (has not been revoked), Ole Town Med may provide healthcare services via telemedicine without the need for me to sign another consent form.

Signature of Patient (or person authorized to sign for patient)

_____ DATE: _____

If authorized signer, relationship to patient : **_____**

Witness: _____ DATE: _____

I have been offered a copy of this consent form (patient's initials) _____

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FINANCIAL POLICY

Healthcare and coverage options have become increasingly complex. We have developed this policy to detail our financial requirements to help you better understand your responsibilities.

*Policy is subject to change at any time.

Insurance Patients

It is your responsibility to know if your insurance has specific rules or regulations, such as the need for precertification, limits on outpatient charges, specific physicians and/or hospitals to use. You should be knowledgeable of any deductibles, co-payments, and or coinsurance. This applies to all payers regardless of whether or not our providers participate.

The responsibility for payment of services is the direct responsibility of the patient. Your health benefit plan is an arrangement between you, the enrollee, and the insurance company, HMO, or your employer. Your health benefit plan determines your coverage, requirements, and establishes the limit on your coverage for medical services based on what they determine is medically necessary. It is your responsibility to return all requested information to your insurance company and our office. If this information is not returned within a specific time frame so the claim may be processed, then the entire balance becomes your responsibility. However, we will do our best to assist you with the understanding of your proposed treatment and in answering questions related to your insurance.

Copays, Coinsurance, Deductibles, and Non Covered Services

Insurances will be verified during the check-in process. Our staff will then have access to your insurance information. Copays will be expected before your visit during this time. During check- out, your coinsurance and deductibles will be figured and collected. Payment must be paid in full before receiving prescriptions or school/work excuses. If non covered services are performed during your visit then you are responsible for these at the time of services.

Cash Pay Patients

Payment is due in full when services are rendered. If you need an estimate of cost, please let the provider know before services are performed.

Medical Records Charge

Ole Town Med will refer to 11-1-52, Mississippi Code of 1972 which states.

- Maximum copy charge is $20.00 for up to 20 pages
- $1.00 per page for the next 80 pages
- $.50 per page for all pages thereafter
- 10 percent of the total charge will be added for postage and handling
- Actual cost of re-producing x-rays or other special records

Collections and Legal Fees

If total balance is not paid within 90 days, your account may be placed in an outside collection agency. You are responsible for all collections and legal fees that may accumulate after this action is taken.

- Ole Town Med realizes that medical care can often become very expensive. If you have concerns about your ability to pay for services, we recommend that you contact us for assistance in management of your account. Should you have any questions in regards to our financial policy then we encourage you to ask. It is our goal, not only to provide the best quality medical care, but to help you by answering any questions you may have.

Patient Signature	**Date**	**Witness**

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NOTICE OF PRIVACY PRACTICES

- This notice describes how your health information may be used, disclosed and how you can access this information.
- At Ole Town Med. we will strive to keep your health information secure and confidential. A new law requires us to maintain your privacy, to give you this notice and to follow the terms of this notice.
- The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file or a referral to a specialist doctor whom we may involve in your care.
- We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.
- We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.
- We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.
- We may use your information to contact you. For example, we may send newsletters or other information. We may also need to call and remind you about appointments. If you are not at home, we may leave this information on your answering machine or with a person who answers the phone.
- If an emergency, we may disclose your health information to a family member or another person responsible for your care.
- We may release some or all of your health information when required by law.
- If this practice is sold, your information will become the property of the new owner.
- Except as described above, this practice will not use or disclose your health information without prior written authorization.
- You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.
- You have the right to know of any uses or disclosures we make with your health information beyond and above normal uses.
- As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.
- You have the right to transfer copies of your health information to another practice. We will mail your files for you.
- You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.
- You have the right to request an amendment or change to your health information. Give us your request to make changes in writing, if you wish to include a statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add new information.
- You have the right to receive a copy of this notice. If we change any details of this notice, we will notify you of the changes at your next appointment / visit after the effective date of change.
- You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, SW, Room 509-F, Washington, DC 20201. You will not be retaliated against for filing a complaint.
- However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer at 662-234-9112.

This notice became effective as of April 14, 2003.

Acknowledgement
I have received a copy of the Ole Town Med's Notice of Privacy Practices. Date_____

Signature _____ Print Name _____

Witness _____

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PATIENT ARBITRATION AGREEMENT

Agreement to Arbitrate: It is understood that any dispute, claim or controversy arising out of or relating to the performance of medical services, including but not limited to patient fees, informed consent, negligence or medical malpractice between Patient (whether a minor or an adult), or the heirs-at-law or personal representative of Patient, as the case may be, and the clinic will be determined by submission to arbitration as provided by Mississippi law, and not by a lawsuit or resort to court process except as Mississippi law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such disputes decided on by a court of law before a jury, and instead are accepting the use of arbitration.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician / practitioner, and the physician's / practitioner's partners, associates, association, corporation or partnership, and the employees, agents and estates of any if them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the physician / practitioner to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

All parties agree that their relationship affects interstate commerce and that this Agreement shall be government by the Federal Arbitration Act, and , if not, by Mississippi Law. The party requesting arbitration shall bear all costs of the arbitration, except the Patient is not required to pay any more than $125, with the Clinic bearing the other arbitration costs. However, each party is solely responsible for their own attorney, expert, and other associated costs, expenses, and litigation fees on their behalf.

This agreement may be rescinded by written notIce by either party within fifteen (15) days of signature. However, any claim or dispute related to medical services rendered after execution of this Agreement and prior to the date of such written notice of rescission shall be subject to the terms of this Agreement. Written notice of such rescission may be given by a guardian or conservator of Patient if the Patient is a minor or incapacitated. This agreement may be modified only by the signed agreement by each party or it's authorized representative. If any portion of this Agreement is found unenforceable, that portion shall be stricken and the remainder of this Agreement fully enforced. If a court rules that the dispute must be litigated and not arbitrated, Patient agrees the suit will be heard in the county where the services were rendered.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY CLAIM OF NEGLIGENCE OR MEDICAL MALPRACTICE DECIDED BY NEUTRAL BINDING ARBITRATION AND YOU ARE GIVING UP YOUR STATUTORY AND CONSTITUTIONAL RIGHT TO A JURY OR COURT TRIAL.

If a parent or guardian has signed on behalf of their minor child or ward, such parent or guardian hereby attests that he / she has full legal authority to execute this Arbitration Agreement on behalf of said child or ward. Furthermore, said parent or guardian hereby agrees to indemnify and hold harmless the Clinic from any claim, demand or loss which may occur in the event said parent or guardian does not, in fact, have such legal authority.

_____ _____

Signature of Patient or Guardian **Date**

_____ _____

Signature of Clinic Representative **Date**