Miller County Medical Center R.E. Jennings Clinic
Miller Specialty Clinic
208 North Cuthbert Street Colquitt, GA 39837
Phone (229) 758-3304 Fax :(229)758-6622

CONDITIONS FOR TREATMENT

Patient Information

Patient's Name:		□Mr. □Mrs. □ Miss □ Ms.	Marital status ☐ Single ☐ Mar ☐ Div ☐ Sep ☐ Wid
SSN:	Birthdate:	Age:	Sex: □ M □F
Mailing Address:	City:	State:	Zip
Phone Number:	Alternate Phone Number:		
Race: □Black/African American □ White □ Hispanic □ Other	Ethnicity: □ Hispanic □ Non/Hispanic		
Email Address:	Employer:	Employer Phone No. ( )	

IN CASE OF EMERGENCY

Name of Friend or Relative:	Relationship to Patient:	Best contact phone#:
Do you have an Advance Directive or Living Will □ No □ Yes		

PATIENT PORTAL

By providing the following information, please understand that you will be sent an invitation to join the Miller County Hospital Patient Portal. After you accept your invitation, you will be allowed to view your discharge information for each visit encounter, view your labs, view your medication refills, request an appointment, and have access to other important information.

Due to security reasons, if you forget your security question, you need to call and request another invitation to the portal.

Name	
Date of Birth	
Email	
Last four digits of Social Security Number	

Signature:_____ Date:_____

Revised
November 2020

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PATIENT ACKNOWLEDGEMENT OF NOTICE 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 MILLER COUNTY HOSPITAL AND MILLER NURSING HOME 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 hospital.

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 this Notice of Privacy Practices, I may contact:

Alisha McKinney, HIPAA Privacy Officer
209 North Cuthbert Street
Colquitt, GA 39837
Phone: (229) 758-5909
Fax: (229) 758-4242

HIPAA RIGHT OF ACCESS FORM FOR FAMILY MEMBER(S)/FRIEND(S)

If someone calls, visits, or ask about you, can we acknowledge that you are here? □ Yes □ No

I, _____, consent for Miller County Medical Center to talk with the following people regarding my medical care. The doctor or nurses will not talk to anyone, regardless of relationship, if their name is not listed.

NAME OF PERSON TO WHOM WE COMMUNICATE	RELATIONSHIP	PHONE NUMBER

PATIENT SIGNATURE DATE

WITNESS SIGNATURE DATE

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CONDITIONS FOR TREATMENT

MEDICAL CONSENT FOR TREATMENT

The undersigned hereby authorizes Miller County Medical Center to furnish the necessary treatments, procedures, ordered exams, x-rays, drugs, supplies, or hospital services as may be ordered or requested by the attending, consulting, or referring physician(s). The undersigned acknowledges that no guarantee or assurance has been made as to the results of treatment, surgery, or examinations in the hospital.

CONSENT TO TREAT A MINOR (IF APPLICABLE)

The patient is unable to consent because he/she is either a minor, blind, or otherwise impaired. I, therefore, consent for the patient and acknowledge the above conditions to care.

RELEASE OF INFORMATION

The undersigned hereby authorizes Miller County Medical Center, the radiologist, pathologist, and/or attending or consulting physicians, the hospital and/or physicians to release to any insurers, ambulance providers, their representatives or other third parties confidential information; including copies of medical records that relate to treatment, payment, or operational activities, related to this dated hospital.

ASSIGNMENT OF BENEFITS

In the event the undersigned and/or patient is entitled to hospital and/or physician benefits of any type whatsoever arising out of any insurance policy or any other party liable to the patient, such benefits are hereby assigned to Miller County Medical Center, and/or any physician having performed services for this patient during his/her stay at Miller County Medical Center, and the radiologist, pathologist, and/or other attending or consulting physician, for application to the patients bill. I hereby certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediators or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization to submit a claim to Medicare for payments to me

GUARANTEEE OF ACCOUNT

I hereby acknowledge responsibility for this account and assume a guarantee payment of all hospital expenses incurred during the admission. I understand that I am financially responsible to the hospital for charges not paid by insurance. I understand this amount is due upon billing. Arrangements for monthly payment plans are available through the business office.

MEDICARE AND/OR MEDICAID

I certify that the information given to me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

PERSONAL VALUABLES

The hospital maintains a safe for safekeeping of money and valuables. The hospital shall not be liable for the loss or damage to any personal property, unless deposited with the hospital for safekeeping. (Examples of Personal property include dentures, jewelry, cell phone, hearing aids, glasses, money/credit cards, prosthesis devices, articles of clothing, etc.)

Acknowledgement of non-physician services

The Hospital Authority of Miller County and its affiliates utilize the services of nurse practitioners and physician assistances. A physician may not be present during all hours services are furnished to the patient.

The undersigned does acknowledge that he/she has read this acknowledgement and has freely and voluntary signed the same in their individual capacity or as the parent or legal guardian of a minor child or representative of an incapacitated adult.

Signature of Patient/Responsible party	Date	Relationship to Patient
Signature of Witness		Date

Revised
November 2020

Hospital Authority of MILLER COUNTY

Name_____ **DOB:** ____-_____-_____ **Date:** ____/_____/_____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Depression Screen	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things?	☐ 0	☐ 1	☐ 2	☐ 3
2.Feeling down, depressed, or hopeless	☐ 0	☐ 1	☐ 2	☐ 3
3. Trouble falling or staying asleep, or sleeping too much?	☐ 0	☐ 1	☐ 2	☐ 3
4. Feeling tired or having little energy?	☐ 0	☐ 1	☐ 2	☐ 3
5. Poor appetite or overeating?	☐ 0	☐ 1	☐ 2	☐ 3
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down?	☐ 0	☐ 1	☐ 2	☐ 3
7. Trouble concentrating on things, such as reading the newspaper or watching TV?	☐ 0	☐ 1	☐ 2	☐ 3
8. Moving or speaking so slowly that other people have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual?	☐ 0	☐ 1	☐ 2	☐ 3
9. Thoughts that you would be better off dead, or hurting yourself?	☐ 0	☐ 1	☐ 2	☐ 3
10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with people?	☐ Not difficult at all	☐ Somewhat difficult	☐ Very difficult	☐ Extremely difficult

I decline the PHQ-9 assessment at this time ☐

PREVENTION (approximate dates)

Females	**Males**
Mammogram: □ No □ Yes: _____/_____/_____	Annual Prostate Exam: □ No □ Yes: ____/____/____
Pap Smear: □ No □ Yes: _____/_____/_____	PSA Cancer Test: □ No □ Yes: _____/_____/_____
Colonoscopy: □ No □ Yes: _____/_____/_____	Colonoscopy: □ No □ Yes: _____/_____/_____
Blood Stool Test (FIT): □ No □ Yes: ____/____/____	Blood Stool Test (FIT): □ No □ Yes: ____/____/____
Influenza Vaccination: □ No □ Yes: ____/____/____	Influenza Vaccination: □ No □ Yes: ____/____/____
Pneumonia Vaccination: □ No □ Yes: ___/____/____	Pneumonia Vaccination: □ No □ Yes: ___/____/___
Shingles Vaccination: □ No □ Yes: ____/____/____	Shingles Vaccination: □ No □ Yes: ____/____/____
Bone Density: □ No □ Yes: ____/____/____	Bone Density: □ No □ Yes: ____/____/____
Other:	Other:

Who is your primary care provider? _____

Are you a smoker? Yes☐ No☐ **if yes, are you thinking about quitting or ready to quit?** Yes☐ No☐

Do you have diabetes? Yes☐ No☐ **When was your last Hemoglobin A1C?** ___/___/___ **Level**_____%

Blood pressure ____/____ **(>140/90 need scheduled follow up)**

FALL RISK SCREEN

Do you worry about falling: □ Yes □ No
Do you feel unsteady when standing or walking: □ Yes □ No
Have you had a fall in the past year: □ Yes □ No **If yes what date:** ___/___/___

INFORMED CONSENT FOR TELEMED SERVICES

PATIENT NAME : _____ LOCATION: _____	DATE OF BIRTH: _____	MEDICAL RECORD #: _____
PHYSICIAN NAME: _____LOCATION: _____ CONSULTANT NAME: _____LOCATION: _____ CONSULTANT NAME: _____LOCATION:_____		DATE CONSENT DISCUSSED: _____

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to Miller County Medical Center providing health care services to me via telemedicine.

I understand that the laws that protect 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 coinsurances that apply to my telemedicine visit.

I understand that I have the right to withhold or withdraw 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 at any time by contacting The Langdale Company at (229) 242-7450. As long as this consent is in force (has not been revoked) Miller County Medical Center may provide health care services to me via telemedicine without the need for me to sign another consent form.

I confirm that I have read and fully understand both the above and the *Telemedicine: What to Expect* form provided. All blank spaces have been completed prior to my signing. I have crossed out any paragraphs or words above which do not retain to me.

Authorization to Release Information

I hereby authorize Miller County Medical Center to release any medical or incidental information that may be necessary for either medical care or in processing applicants for financial benefits.

Patient/Relative/Guardian Signature	Print Name
Relationship to Patient (if required)	Date
Witness Signature	Date
Interpreter Signature (if required)	Date

FIVESTAR Telehealth Clinic

Appointment Cancellation and No-Show Policy

Our goal at the FIVESTAR Telehealth Clinic is to provide quality primary care in a timely manner. Effective immediately, the clinic must be provided 24-hour notice if you cancel your Clinic appointment. Early cancellation will allow the clinic staff to schedule someone else in that appointment time.

Patients who fail to show for their scheduled appointment or did not notify the clinic within 24 hours of their scheduled appointment time, will be contacted by clinic staff to reschedule a new appointment time.

Appointments will not be automatically rescheduled. Patients must contact clinic staff before a new appointment will be scheduled.

Second No Show or Failure to Cancel Timely

Patients who continue to fail to show for their appointment or fail to cancel their appointment for the second time may have their clinic access privileges suspended for six months.

Participants in the Diabetes Management Program may also be temporarily removed from the program and subject to loss of other program benefits such as free diabetic medications.

How to Cancel Your Appointment

To cancel or reschedule appointments call Carsen Howell, RN at 478-234-0094 or TLC Benefit Solutions, Inc. at 877-949-0940. I acknowledge that I have read and understand the above policy.

_____ _____

Patient Signature Date

_____ _____

Patient Printed Name Date

_____ _____

Witness Signature Date