

MCKINNEY COMMUNITY HEALTH CENTER, INC.
PATIENT INFORMATION

Date _____

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____

State _____ Zip Code _____ Social Security No. _____

Home Phone # _____ Work Phone # _____

Cell Phone # _____ Is it OK to leave a message? Yes _____ No _____

Veteran: Yes _____ No _____ Date of Birth _____ Sex _____

Race: (Please circle one)

White Black/AA Asian
American Indian/Alaskan Native Native Hawaiian Other Pacific Islander

Marital Status _____ Ethnicity: Are you Hispanic or Latino? Yes _____ No _____

Pharmacy _____ City _____

Name of person in case of emergency _____

Relationship _____

Emergency contact phone #'s _____

Check appropriate payer source

Pay by:
Medicaid _____ Medicare _____ Self Pay _____ Sliding Fee Scale _____

Insurance _____ WellCare _____ Amerigroup _____ PeachCare _____

Name of Insurance Carrier _____

(Please provide a copy of your insurance card(s))

Card holder (Name) _____

Relationship _____ Phone #'s _____

Cardholder Date of Birth _____ Social Security No: _____

Note: In order to file insurance claims, we are required to have the Date of Birth and the Social Security Number of the policy holder.

Signature _____ Date _____

Employer Information

Employer _____

Address _____

City _____ State _____ Zip Code _____

Income levels:

Because McKinney Community Health Center is a Federally Qualified Health Center, we are required to report certain income levels on our patients. This information is for McKinney Community Health Center, Inc. use only and will not be distributed or published in any way. Please complete the following information.

What is your annual household income?

- 0 – \$10,400
- \$10,401- \$13,999
- \$14,000 – \$17,599
- \$17,600 – \$21,199
- \$21,200 - \$24,799
- \$24,500 – \$28,399
- \$28,400 – \$31,999
- \$32,000 and above

Number of family members in household: _____

Characteristics: (Please answer the following. Please circle one)

Homeless:	Y	N	Date Started _____
Migrant Worker:	Y	N	
Seasonal:	Y	N	Date Started _____
Transitional:	Y	N	Date Started _____
Street:	Y	N	Date Started _____

NOTICE OF PRIVACY PRACTICES

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.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of use or disclosure, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclose in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment: We may use and disclose medical information about you so that treatment and services you receive at the practice may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may disclose your record to a insurance company, so that we can get paid for treating you.

For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the practice of the hospital. For example, we may disclose medical information about you to people outside the practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations: We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, medical students, and other practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

WHO WILL FOLLOW THIS NOTICE: This notice describes our practice’s policies and procedures and that of any health care professional authorize to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION: We create a record of the care and services you receive at the practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the practice, whether made by practice personal doctor. The law requires us to make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and, to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected health care information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: corners, medical examiners and funeral directors; health oversight activities; inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and other; public health risks; and worker’s compensation.

Notice of Individual Rights

You have the following rights regarding medical information we maintain about you;

Right to a Paper Copy of this Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the practice. To request an amendment, your request must be made in writing and submitted to the Privacy Compliance Office and you must provide a reason that supports your request. We may deny your request for amendment.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care options. You also have the right to request a limit on the medical information we use or disclose about you to someone who is involved in your care, likely a family member or friend. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Compliance Officer.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request n writing to the Privacy Compliance Officer; and you must specify how or where you wish to be contacted.

Right to and Account of Disclosures: You have the right to request an “accounting of disclosures.” This is a list of disclosure we made of medical information about you. To request this list of accounting disclosures, you must submit your request in writing to the Privacy Compliance Officer.

Changes To This Notice: We reserve the right to change this notice. We will post a copy of the current notice in the practice’s waiting room.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact the Privacy Compliant Officer at 218 Quarterman Street, Waycross, GA 31501. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Other Uses of Medical Information: Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Compliance Officer at (912) 462-6222.

I acknowledge by signing below that I have received a **Notice of Privacy Practices and Notice of Individual Rights**

Patient or Patients Representative _____
Date

McKinney Community Health Center, Inc

Waycross
218 Quarterman St.
Waycross, GA 31501-3547

Nahunta
122 North Main Street
Nahunta, GA 31553-9806

Blackshear
623 Sycamore St.
Blackshear, GA 31516-2119

St. George
Rt. 2 Box 915
St. George, GA 31562-9687

Folkston
101 A East Main St.
Folkston, GA 31537-3012

Signature on File

I understand that Physician Assistants (PA) perform services in this facility. I understand that I have the right to see the Physician prior to receiving any prescription drug or device from the Physician Assistant.

Printed Name: _____

Signature: _____ Date: _____

McKinney Community Health Center, Inc

INTERNAL MEDICINE

Please complete this form in full. This information will not be released to anyone without your written permission.

(Please Print)

Today's Date: _____

Full Name: _____ Date of Birth: _____ Age: _____

Who referred you to us? _____

Family Doctor: _____

Other Doctors seen in last 3 years: _____

Current health problems or symptoms: _____

Medications: _____

Past Medical History

Please check all items and give approximate date if illness was in the past.

	NO	YES NOW	YES PAST		NO	YES NOW	YES PAST
CADIOVASCULAR				PULMONARY			
High Blood Pressure				Emphysema			
Heart Murmur				Bronchitis, Chronic			
Abnormal Mythm				Asthma			
Heart Attack				Tuberculosis			
Rheumatic Fever				Pneumonia			
Angina				Other			
GASTROINTESTINAL				UROLOGIC			
Gallstones				Kidney Stones			
Ulcers				Kidney/Bladder Infections			
Cirrhosis or Hepatitis				Prostate Problem (men)			
Colon or Bowel Problem				Other			

	NO	YES NOW	YES PAST		NO	YES NOW	YES PAST
OTHER				WOMEN			
Stroke				Menstrual Problems			
Migraine				Breast Disease			
Psychiatric Illness				Breast Cancer			
Seizure				Ovarian Cyst			
Anemia				Age Period Started: _____			
Diabetes				Age Period Stopped: _____			
Thyroid Disease				Number of Pregnancies: _____			
Gout				Children: _____			
Blood Clot (Phlebitis)				Miscarriages: _____			
Arthritis							
Glaucoma							
Depression							
Cancer							
Type:							
Skin Disease							
Type:							

List all surgery, type and year

<u>Surgery</u>	<u>Type</u>	<u>Year</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you allergic to any:

Medications:

_____	_____
_____	_____
_____	_____
_____	_____

Other (Foods, etc.)

_____	_____
_____	_____
_____	_____

	NO	YES	IN PAST
HABITS			
Do you smoke			
Chew tobacco/use snuff			
Drink any alcohol			
Drink Beer			
Always wear seat belt			
Live with a smoker			

FAMILY HISTORY

Check condition and enter the relationship of

	NO	YES	RELATIONSHIP
Heart Disease			
Diabetes			
Stroke			
Alcoholism			
Liver Disease			
Cancer of colon			
Cancer of breast			
Cancer of ovaries			
Cancer of Prostate			
Mental Illness			
Suicide			

X-RAYS

When was last:

	None	Yes	Date
Mammogram			
Chest X-Ray			
Colon X-Ray			

IMMUNIZATIONS

	None	Yes	Date
Influenza Vaccine			
Pneumonia Vaccine			
Tetanus			
Hepatitis			

Have you ever been treated for AIDS? No Yes

FAMILY MEMBERS MEDICAL ILLNESS (ES)

Father _____

Mother _____

Brother(s) _____

Sister(s) _____

Children _____

HAVE YOU EVER BEEN HOSPITALIZED OTHER THAN AS NOTED ABOVE?

WHERE?

WHEN?

WHY?
