MedLink GEORGIA

PATIENT INFORMATION

PATIENT INFORMATION – Please Print

Last Name ______________________________
First Name ______________________________
Preferred Name ______________________________
Middle ______________________ Suffix ________
Former Last name(s) ______________________
Gender Reported at Birth [ ] Male [ ] Female
Birth Date ______________________________
SS Number ______________________________
Address ______________________________
____
Zip Code ________ County of Residence ________
City ____________________ State __________
Home Phone ______________________________
Cell Phone ______________________________
Work Phone______________________________
e-mail______________________________
I prefer to be contacted by: [ ] e-mail [ ] Text Message
[ ] Home Phone [ ] Work Phone [ ] Cell Phone
[ ] OK to leave message [ ] Do NOT leave a message
[ ] Don't call Home Number [ ] Don't call Work
[ ] Other ______________________________
Provider ______________________________
Pharmacy ______________________________
Imaging Center ______________________________
Language:
[ ] English [ ] Spanish
[ ] Other ______________________________
Race [ ] American Indian/Alaskan Native [ ] Asian
[ ] Black/African American [ ] Native Hawaiian
[ ] Other Pacific Islander [ ] White
[ ] Other ______________________________
Ethnicity [ ] Hispanic/Latino [ ] Not Hispanic
[ ] Other ______________________________

Marital Status [ ] Married [ ] Single
[ ] Widowed [ ] Divorced
[ ] Separated [ ] Other ____________

Are you Homebound? [ ] Yes [ ] No
Migrant Worker Status [ ] Migrant [ ] Seasonal
[ ] Not a migrant or seasonal farmworker
Living Situation [ ] Doubling Up [ ] Shelter
[ ] Street [ ] Transitional
[ ] Not Homeless [ ] Other ________
Do you Live in Public Housing? [ ] Yes [ ] No
Are You a Veteran? [ ] Yes [ ] No

Guardian's Last Name ______________________________
First Name ____________ Middle __________ Suffix__
Next of Kin's Last Name ______________________________
First Name ____________ Middle __________ Suffix__

EMERGENCY CONTACT INFORMATION

Name ______________________________
Relationship ______________________________
Home Phone ______________________________
Cell Phone ______________________________

EMPLOYMENT INFORMATION

Employer's Name ______________________________
Employer's Phone ______________________________
Usual Occupation ______________________________
Usual Industry ______________________________

GUARANTOR INFORMATION (to whom statements are sent)

Relationship to Patient ______________________________
Last Name ______________________________
First Name ______________________________
Middle ______________________ Suffix ________
Birth Date ______________________________
Address ______________________________
Zip Code ____________
City ____________________ State __________
SS Number ______________________________
Work Phone Number______________________________
Cell Phone ______________________________

How did you find us? [ ] Already a patient [ ] Friend
[ ] Yellow Pages [ ] Radio
[ ] Newspaper Ad [ ] Hospital
[ ] TV [ ] Web Site
[ ] Other ______________

SEXUAL ORIENTATION AND GENDER IDENTITY

NOTE: This data is required for federal statistical reports and is not associated with individual patients

Sexual Orientation
[ ] Lesbian, gay, or homosexual
[ ] Straight or heterosexual
[ ] Bisexual [ ] Something else
[ ] Choose not to disclose

Gender Identity
[ ] Male [ ] Female
[ ] Transgender male/female-to-male
[ ] Transgender female/male-to-female
[ ] Gender queer
[ ] Other [ ] Choose not to disclose

INSURANCE and PAYMENT INFORMATION

Insurance Status Private Insurance [ ] Medicare [ ] Medicaid [ ] Uninsured [ ]	***Do you want to apply for fee discounts based on your household income and size?*** [ ] Yes [ ] No
Number living in Household ____________	***If no, do you meet criteria for income greater than 250% of qualified income on the table available?*** [ ] Yes [ ] No
Combined Yearly Household Income, please check below:	***Would you like information about or assistance with***
[ ] $0 -12,760.00 *(100% and below)*	[ ] Applying for fee Discounts [ ] Applying for Medicaid
[ ] $12,761.00 – 15,949.00 *(101-150%)*	[ ] Medicare [ ] PeachCare for Kids
[ ] $15,950.00 – 19,139.00 *(151-200%)*	[ ] the Affordable Care Act Health Insurance
[ ] $19,140.00 – 25,519.00 *(151-200%)*	[ ] Affordable Medications [ ] Other ____________
[ ] $25,520.00+ *(greater than 200%)*	

Insurance Plan Name:

Policy Holder if other than the patient	Policy Information
Last Name ____________	Patient's Relationship to Policy Holder: ____________
First Name ____________	ID/Certification No.: ____________
Middle ____________	Policy/Group Number: ____________
Address ____________	
City ________ State ____ Zip Code ______	Employer Name ____________
Birth Date ________ Gender [ ] Male [ ] Female	

SECONDARY INSURANCE INFORMATION

Insurance Plan Name: ____________

Policy Holder if other than the patient	Policy Information
Last Name ____________	Patient's Relationship to Policy Holder: ____________
First Name ____________	ID/Certification No.: ____________
Middle ____________	Policy/Group Number: ____________
Address ____________	
City ________ State ____ Zip Code ______	Employer Name ____________
Birth Date ________ Gender [ ] Male [ ] Female	

ASSIGNMENT, RELEASE, and CONSENT

- I hereby authorize the MedLink Georgia, Inc., to furnish information to insurance carriers concerning my illness and treatment, and direct the insurer to pay, without equivocation, directly to the MedLink Georgia, Inc., all benefits due as a result of treatment.
- I understand that I am financially responsible for all non-covered services, copays, deductibles, and/or co-insurance. I authorize and consent for MedLink Georgia to bill me directly for recommended services performed that are not covered under the terms of my health plan.
- I authorize the physician to release any medical information required to process claims.
- A copy of this authorization will be as valid as the original.
- I consent to routine medical care rendered to me or my dependents by the attending provider/physician(s).
- I consent to treatment by a Physician's Assistant or Advanced Practice Nurse acting under the supervision of a MedLink Georgia Physician.
- I acknowledge that I have the right to explanations about my care and treatment in a language and manner that assures I understand my treatment options.
- I understand that I have the right to refuse treatment after risks and benefits have been explained.
- 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 required and is NOT a requirement to obtain other services at MedLink Georgia, Inc. I understand that I cannot be turned away for Title X services for inability to pay.
- I understand that some professional medical services such as laboratory and pathology services may be independent contractors and will bill me separately for their services.
- I acknowledge treatment may be rendered in an emergency without further consent.
- I understand that MedLink Georgia is not liable for any act or omission in the following of provider/physician(s) instructions.

I certify that all information given by me is true.

Signature ______________________ Date ____________

[ ] Patient [ ] Parent [ ] Guardian

Limited Care Waiver for Dental Patient

MedLink Georgia - Commerce Dental wishes to provide you acute care for your dental problem today. If absolutely necessary, you may be scheduled for one additional visit to address the problem.

If you wish to have all your dental needs addressed following your emergency visit, we can recommend community dental offices who are accepting new adult patients for comprehensive care.

Currently, MedLink Georgia – Commerce Dental can only provide comprehensive services for:

- Children (ages 17 or less)
- Pregnant Women
- MedLink Georgia medical patients with certain conditions referred to dental services

However, we recognize there is a tremendous need for acute/emergency dental care, and we have structured our program to provide you these critical services.

I understand that by receiving acute/emergency care from MedLink Georgia , I am not an established patient of the dental provider(s). I will not have a comprehensive treatment plan, since I need to receive acute/emergency care right away. I understand MedLink Georgia – Commerce Dental does not assume responsibility for my ongoing dental care.

Patient Signature ___________________________________ Date ______________

Patient-Provider Partnership Expectations and Agreement

The health and wellness of our patients is a top concern at MedLink Georgia. Providing the best possible care to every patient is our primary goal. The only way we can meet this goal is if your doctor and you, the patient, work together. This concept is called a Patient Centered Medical Home.

As our patient, your responsibilities are:

- Ask questions, share your feelings, and be part of your care
- Be honest about your history, symptoms and other important information about your health
- Tell your healthcare team about any changes in your health and wellbeing
- Take all of your medicine and follow your doctor's advice
- Make healthy decisions about your daily habits and lifestyle
- Prepare for and keep scheduled visits or reschedule visits in advance according to the expectations below
- Call us first with all problems, unless it is a medical emergency
- *Notify the office immediately if you have been admitted to a hospital, been seen in an emergency department, or had imaging or lab work done*
- End every visit with a clear understanding of your provider's expectations, treatment goals, and future plans

As your provider office, our responsibilities are:

- Explain diseases, treatments, and results in an easy-to-understand way
- Take time to listen to your feelings and questions and help you make decisions about your care
- Keep your treatments, discussions and records secure
- Provide 24-hour access to medical care and same day appointments, whenever possible
- Provide instructions on how to meet your health care needs when the office is not open
- Care for you to the best of our abilities based on the understanding we have of your current medical conditions
- Provide you with clear directions about medicines and other treatments
- When necessary, direct and coordinate your care through referrals to specialists and community resources
- End every visit with clear instructions about expectations, treatment goals, and future plans

Patient Scheduling Expectations:

We work diligently to provide you with quality healthcare in an efficient manner. In order to optimize the patient-staff schedule and work flow, we ask that you please comply with the following expectations:

- All appointments must be scheduled, including same day appointments. We will do our best to schedule you for a same day appointment as provider and staff availability allow. Please understand that you may have longer than expected wait times when seen as a same day appointment.
- If you arrive 10 minutes or later for your appointment, we reserve the right to reschedule for a later day appointment or another day as you choose.
- Twenty-four hour appointment cancellation is required. If a same-day appointment needs to be cancelled, please let the staff know as soon as possible. Appointments not cancelled at least one (1) hour prior to the scheduled time will be considered a no-show.
- No-show appointments will have a **$25.00 fee added** to the account. Patients who are seen within five (5) business days will have this fee reversed from their account.
- If a patient has five (5) no-show appointments during a six (6) month period, it may result in discharge from all MedLink Georgia locations.
- New patients should arrive at least 30 minutes prior to a scheduled appointment. Established patients should arrive 15 minutes prior to a scheduled appointment.

______________________________ ______________________________

Patient Printed Name and Signature Date

______________________________ ______________________________

Provider Printed Name and Signature Date

Notice of Privacy Practices
Acknowledgment of Receipt

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I acknowledge that I have received or have been given the opportunity to receive a copy of MedLink Georgia's Notice of Privacy Practices. I also understand that MedLink Georgia has the right to change its Notice of Privacy Practices and that I may contact any office to obtain a current copy of the Notices of Privacy Practices.

I further acknowledge that I have had a chance to ask questions about how my information will be used

_______________________________________ _______________________________
Patient's Printed name Date

_______________________________________ **Or**
Patient's Signature

____
Patient's Representative (Printed) Signature

This document will be filed in the patient's electronic medical record as required by HIPAA regulations. The Notice of Privacy practices will be provided upon request in alternative formats for individuals with disabilities or in a language other than English for people with limited English proficiency.

FOR OFFICE USE ONLY:

We have made the following attempt to obtain the patient's/representative's signature acknowledging receipt of the Notice of Privacy Practices:

- ☐ Patient/representative refused to sign
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Communications barriers prohibited us from obtaining acknowledgement
- ☐ Other ____
  ____

____
Staff Member's Name (Printed) Signature Date

FINANCIAL POLICY

Thank you for choosing us as your Dental Care Provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment. All patients must read and sign this form before seeing the doctor.

As a condition of your treatment by our office, financial arrangements must be made in advance. Our practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AND DISCOVER

TREATMENT PLAN ESTIMATES:
We prepare Treatment Plan Estimates so that patients can understand the estimated cost of their recommended treatment prior to its start. The Treatment Plan Estimate is a good-faith attempt to predict the cost of your treatment based on the facts known to us when the estimate is made. This is only an estimate and all balances remaining after any applicable insurance payments are the patient's responsibility. As your treatment progresses, your dentist may determine in consultation with you that different or additional treatment is necessary and your financial responsibility may change. You will be notified of any such changes prior to services being provided.

DENTAL INSURANCE:
MedLink Georgia participates with a limited number of commercial insurance carriers; however, our office will gladly work with you to help get the maximum benefit available to you. Most dental insurance plans do not cover 100% of your cost of treatment. Therefore, you will be expected to pay your deductible, your ***ESTIMATED*** co-insurance and any differences in the actual charges and the insurance carrier's allowed/reasonable and customary charges (if known, for non-contracted payers) on the day services are rendered. We will gladly file your insurance claim as a courtesy. Many variables exist from carrier to carrier (i.e. deductibles, annual maximums, allowable fee limitations, non-covered procedures and other restrictions); therefore, we cannot guarantee any estimated charges. Because your insurance is an agreement between you and the insurance company, ultimately you are responsible for all charges. Please know that we will do everything possible to see that you receive the full benefits from your insurance company. If for some reason your insurance company has not paid their estimated portion within 60 days from the start of treatment, you are responsible for payment in full at that time. Treatment could be altered if your dental needs change. The patient will be notified of any change(s) in treatment. *We will gladly file all dental claims for any given treatment, however, the balance is YOUR responsibility whether your insurance company pays for your treatment or not. It is your responsibility to inform us of any changes in your insurance coverage.*

USUAL AND CUSTOMARY RATES:
Our practice is committed in providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates

MEDICAID AND CMO'S:
MedLink Georgia does accept Medicaid and Medicaid Care Management Organization (CMO) plans.

SLIDING FEE SCALE:
MedLink Georgia offers a sliding fee discount to patients who qualify. This discount is based on family/household size and income and is dependent on completion of the Sliding Fee Application and the receipt of the required supporting documentation. Please inquire with the medical secretary if you are interested in applying. Payment is expected prior to services being rendered.

NSF CHECK POLICY:
Payments made by check that are not honored by the bank will incur a returned check fee of $25.00 plus any additional bank fees applied. The payment will be reversed from the appropriate account when a check is returned by the bank which could result in additional fees being added to the account.

ASSIGNMENT OF INSURANCE BENEFITS:
I understand that services rendered to me by MedLink Georgia, associated dentists and hygienist (collectively labeled as "Provider") are my financial responsibility and that the Provider will bill my insurance company as a courtesy. I authorize my insurance company to pay my benefits directly to Provider and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of professional service charges over and above this insurance payment.

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or healthcare practitioners.

I also understand that should my insurance company send payment to me, I will submit payment to MedLink Georgia within 48 hours. Any violations of this agreement will, at Provider's election, terminate Patient charge privileges with MedLink Georgia and bring any balance owed by Patient to MedLink Georgia immediately due and payable.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

____________________________________ Date: __________________________
Signature of patient, parent or guardian

Relationship to Patient ____

REQUEST FOR LIMITATIONS AND RESTRICTIONS OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: ________________________ Patient SSN: (last 4 digits) ______________

Patient Date of Birth: ____

Patient Address: ____

____

Under the Health Insurance Portability and Accountability Act of 1996 we may disclose medical information about you to people who may be involved in your medical care such as therapists, family members, clergy, or other persons that are part of your care. You have the right under the Health Insurance Portability and Accountability Act of 1996 to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like 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 limitations and restrictions, you must complete this form and return it to us.

Please describe as specifically as possible the *type of **information*** that you would like for us to restrict or limit. ____

____

□ All information in EHR □ Appointments □ Diagnostic test results

Please describe as specifically as possible ***how*** you would like this information to be restricted or limited.____

____

May only share with

Name	Relationship	Phone
______	______	______
______	______	______
______	______	______

______________________________ Signature of Patient or Legal Guardian

______________________________ Date

For Use by ***the Center*** only:

Date Received ____________ Request Has Been: Accepted ______ Denied _______

Comments: ____

______________________________ Practice Manager/Office Coordinator

______________________________ Date entered into EHR

PATIENT RIGHTS and RESPONSIBILITIES

MedLink Georgia is committed to providing high quality care that is fair, responsive, and accountable to the needs of our patients and their families. We are committed to working with our patients and their families with our goals to not only provide appropriate health care and related services, but also to address any concerns they may have regarding such services. We encourage all of our patients to be aware of their rights and responsibilities and to take an active role in managing and improving their health and strengthening their relationships with our health care team.

YOU HAVE A RIGHT TO:

- Receive high quality care based on professional standards of practice, regardless of your (or your family's) ability to pay for such services.
- Obtain services without discrimination on the basis of race, ethnicity, nation origin, sex, age, religion, physical or mental disability, sexual orientation or preference, marital status, or socio-economic status.
- Be treated with courtesy, consideration, and respect by all MedLink Georgia staff, at all times and under all circumstances, and in a manner that respects your dignity and privacy.
- Expect that MedLink Georgia will maintain the confidentiality of information in your electronic health record.
- Receive information regarding the availability of support services, including translation, transportation, and education services.
- Receive sufficient information to participate fully in decisions related to your health care. If you are unable to participate fully, you have the right to be represented by parents, guardians, family members or other designated surrogates.
- Ask for and receive information regarding your financial responsibility for services.
- Develop advance directives and be assured that all health care providers will comply with those directives in accordance with law.

YOU HAVE A RESPONSIBILITY TO:

- Provide complete and accurate health, medical, and insurance information including an advance directive if appropriate.
- Be considerate and respectful of other patients and MedLink staff.
- Ask questions when in doubt.
- Communicate changes in your health and/ or condition to your care team.
- Follow your providers' instructions or discuss with them any obstacles you may have in complying with your prescribed treatment plan.
- Keep all scheduled appointments and arrive on time.
- Actively participate in planning your care.
- Advise MedLink Georgia of any concerns, problems, or dissatisfaction with services provided or the manner in which (or by whom) they were furnished.
- Understand to the best of your ability your health benefits and any exclusions, deductibles, co-payments, and treatment costs while making a good faith effort to meet financial obligations, including promptly paying for services provided. Known copayments are expected to be paid prior to services being rendered. If outstanding balances exceed $100.00, you will be referred to the Practice Manager or representative to discuss making payment arrangements. Balances left unpaid may be referred to an outside collection agency.
- Use electronic means (patient portal) appropriately to access your patient information.

If you have any questions, concerns, or comments, please request to speak to the Practice Manager. If you feel your question or concern has been unresolved, please contact the MedLink Georgia Administrative office at either comments@medlinkga.org or 706-788-3234.

____________________________ Patient Signature

____________________________ Date