Lewis County Primary Care Center Doing Business As...

PrimaryPlus

Quality Advanced Affordable Healthcare

Welcome to the PrimaryPlus Family!!!

PrimaryPlus believes that our patients are part of our family and we are thankful for the opportunity to care for the people of our communities! We take pride in being your medical home. We are happy to provide you with a comprehensive list of services throughout our many locations including family health, pediatrics, pharmacy, dental, women's health, counseling, occupational medicine, minor emergencies and more! As a Federally Qualified Health Center, PrimaryPlus is also able to provide many options for keeping your healthcare affordable including our Sliding Fee Scale Program and 340B Pharmacy Program (ask for details).

As a new patient, we need to collect some demographic information about you, as well as, get your signature on some important forms that are needed to ensure the best of care. You will find those forms included after this letter. Feel free to print and complete the forms and bring them with you to your appointment—this will save you some time! Please fill free to contact us if you have any questions…and once again, WELCOME to PrimaryPlus!

Our Mission.

The Mission of PrimaryPlus is to provide the highest quality of advanced, affordable health care. Services will be delivered to our customers/patients with enthusiasm, friendliness, honesty, personal pride & company spirit.

Cardinal Value.

We honor the dignity and worth of all people.

Guiding Values.

We are guided by **R.E.S.P.E.C.T.**

Reverence for all life, provided in an

Enthusiastic environment in a

Spiritual, as well as

Professional atmosphere. At all times, we are

Ethical and

Caring, while working as a

Team

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PrimaryPlus Information Form

Medical Record#_____
(office use only)

LEGAL NAME: _____ _____ _____
Last First Middle Maiden

Preferred Name: _____ **Social Security**: _____ - _____ -_____

DOB: _____ **Preferred Provider/Clinician**:_____
(This is the provider that you primarily want to see and to manage your overall care)

Your Address:_____
Street City State/Zip Code

Preferred Pharmacy: _____

Do you speak and understand English? Yes No

Gender: (circle one) Male Female Transgender Other Choose not to disclose
Assigned sex at birth: (circle one) Male Female Choose not to disclose
Pronouns: (circle one) he/him she/her they/them

Sexual orientation: (circle one) Lesbian or gay Straight (not lesbian or gay) Bisexual
Something else Don't know Choose not to disclose

Marital Status: (circle one) Single Married Divorced Widowed Separated

Race: (circle one) White Black Asian American/Indian **Ethnicity:** Hispanic Non-Hispanic
(If biracial, circle the race you most identify as)

Contact Information: (Please list numbers and options we may use to contact you)
Home Phone : _____ Cell/Mobile Phone: _____
Consent to call? Yes No Consent to text? Yes No
Consent to leave message? Yes No Consent to call? Yes No
Work Phone:_____Consent to call? Yes No Consent to leave message? Yes No

Email Address: _____

Employer:_____ **Occupation**:_____

Veteran Status: Veteran Non-Veteran

Agricultural Work Status: Non-Agricultural Employed Year-Around Seasonal Migrant Retired Farmer

Homeless Status: Do you consider yourself homeless? Yes No

Public Housing: Yes No patient declined

PLEASE COMPLETE BACK OF FORM

Insurance: _____Private Insurance _____Medicare _____Medicaid _____Self Pay/No Insurance

Primary Insurance:

Insured/ Spouse Information

Name:_____ Relation:_____ Phone:_____

Birth Date:_____ Social Security:_____- _____- _____

Emergency Contact Information:

Name: _____ Relation:_____ Phone:_____

Primary Caregiver (if applicable):_____ DOB_____
(Person who provides day-to-day care for the patient) Name

Legal Guardian (for minors):_____ DOB _____
Name

Do you have legal documents? Yes No
If yes, please submit appropriate documents to front desk staff

(Non-applicable for children under the age of 18)

Do you have a **Power of Attorney or Health Care Proxy/Surrogate**? Yes No
(An "agent" designated by the patient, the patient's family, or by the courts to make health care decisions for him or her in the event that the patient is unable to do so)

If YES, please submit appropriate documents to front desk staff

Do you have a **Living Will or Advance Directives?** Yes No
(Documents which give the patient a voice in decisions about their medical care when he/she is unconscious or too ill to communicate)

If YES: Please submit to front desk staff to be copied

If NO: And you would like additional information, please ask front desk staff for an informational packet

Patient Signature:_____ Date:_____

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Name of Patient:_____ Date of Birth:_____

Physicians of: *Lewis County Primary Care Center, Inc./ DBA PrimaryPlus*

Date:_____ Time:_____ (a.m.) (p.m.)

1. I, _____(parent/guardian) acting on behalf of _____(patient) am suffering from a condition requiring medical, podiatric and/or dental care. I agree to receive this care. It may include routine diagnostic and medical treatment that the attending physician(s) or others of the health center medical staff consider necessary.
2. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury or even death. I acknowledge that no guarantees have been made to me about the result of examination or treatment in this health center
3. I understand that:
   (a) Normally, except under emergency or extraordinary circumstances, no important procedures are performed upon a patient unless and until he or she has had an opportunity to discuss them with the physician or other health professionals to the patient's satisfaction;
   (b) Each patient has the right to agree or refuse to agree to any proposed procedure or therapeutic course; and
   (c) No patient will be involved in any research or experimental procedure without his or her full knowledge and agreement.
4. I realize that there are medical, nursing and other health care personnel at this health center who are still in training. I understand that they may be present during my care unless I request them not to be present.
5. This form has been fully explained to me, and I am satisfied that I understand its content and significance.

Date of Agreement:_____

_____ _____

(Patient's signature) *(Signature of witness)*

* If the patient is unable to consent or is a minor, complete the following:

Patient (is a minor _____ years old) OR (is unable to consent because

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I HEREBY CONSENT FOR THE FOLLOWING PERSON/PERSONS TO BRING MY UNDERAGED CHILD TO LEWIS COUNTY PRIMARY CARE CENTER, INC FOR TREATMENT.

_____ _____

_____ _____

_____ _____

_____ _____

Parent or Legal Guardian Date

_____ _____

Witness Date

ASSIGNMENT & RELEASE: I, the undersigned certify that I (or my dependent) have insurance coverage with _____And assign directly to Dr._____

All insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the Dr. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature Relationship Date

MEDICARE AUTHORIZATION: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr._____ _____for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information to the insurer or agency shown. In Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____

Beneficiary Signature Date

HIPAA Notice of Privacy Practices

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LEWIS COUNTY PRIMARY CARE CENTER, INC. dba PrimaryPlus
211 KY 59, PO Box 550 Vanceburg, KY 41179
(606) 796-3029

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that my identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1.Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when requirements of Section of the Department of Health and Human Services to investigate or determine our compliance wit h the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under the federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for the notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right o file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature _____ Date _____

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ACKNOWLEDGEMENT AND AUTHORIZATION:

- **I have read and understand the HIPAA/Privacy Policy for LEWIS COUNTY PRIMARY CARE CENTER INC DBA PRIMARYPLUS**

Signed_____ **Date:**_____

- **I hereby assign my insurance benefits to be paid directly to the healthcare provider**

Signed_____ **Date:**_____

- **I authorize LEWIS COUNTY PRIMARY CARE CENTER INC DBA PRIMARYPLUS to release medical information required to process my claim**

Signed_____ **Date:**_____

- **I have read and understand the Financial Policy for LEWIS COUNTY PRIMARY CARE CENTER INC DBA PRIMARYPLUS**

Signed_____ **Date:**_____

- **I authorize LEWIS COUNTY PRIMARY CARE CENTER INC DBA PRIMARYPLUS to obtain/have access to my medication history**

Signed_____ **Date:**_____

- **I authorize my provider's office to contact me by mobile phone**

Signed_____ **Date:**_____