Georgetown Family Physicians
EXPRESS CARE
1502 Oxford Drive, Suite 100
Georgetown, KY
(502) 570-3785

PATIENT REGISTRATION FORM

Today's Date____/____/____

PATIENT INFORMATION

Patient Name Last First Middle			Birthdate / /	Age Sex □ M □ F □ T
Is this your legal name? □ YES □ NO	If not, what is your legal name?		Home Phone Number ( )	SS#
Street or Mailing Address (circle one)	City	State	Zip Code	Cell Phone Number ( )
E-Mail Address	Child lives With:			

Siblings (Name and Date of Birth):

Student Status: □F – Full-Time Student □P – Part-Time Student □N – Not a Student
School Attended:

Race: □American Indian/Alaska Native □Asian □Native Hawaiian/Pacific Islander □Black/African American □White □Hispanic □Other □Declined

Ethnicity: □Hispanic or Latino □Not Hispanic or Latino □Declined

Language: □English □Spanish □Indian □Japanese □Chinese □Korean □French □German □Russian □Other _____

Pharmacy: | Do you have a living will? □ YES □ NO

Referred By (Please check one box)
□ Dr. _____ □ Insurance □ Hospital □ Family □ Friend □Yellow Pages □ Other _____

Other Family Members Seen Here

PCP Name | Phone #

PARENT/GUARDIAN/RESPONSIBLE PARTY INFORMATION

Responsible Party: Name		Address	Home Phone Number
Birth Date / /		E-Mail Address	( )
Occupation	Employer	Employer Address	Employer Phone Number ( )
Second Parent/Guardian Information: Name		Address	Home Phone Number
Birth Date / /		E-Mail Address	( )
Occupation	Employer	Employer Address	Employer Phone Number ( )

INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Is this visit for one of the following? □ WORKERS COMPENSATION (WC)
□ OCCUPATIONAL MEDICINE (OM) □ MOTOR VEHICLE ACCIDENT (MVA) □ ACCIDENT DATE _____

Does the patient have healthcare coverage? □ YES □ NO | Insurance Name

Name of Insured	Social Security Number - -	Birth Date / /	Effective Date / /	Group ID	Subscriber ID (Policy Number)

Patient Relationship to Insured □ Self □ Spouse □ Child □ Other _____

Name of Secondary Insurance	Name of Insured	Date of Birth / /	Group ID	Subscriber ID (Policy Number)

Patient Relationship to Insured □ Self □ Spouse □ Child □ Other

EMERGENCY CONTACT

Name (Last, First)	Relationship to Patient	Home Phone Number ( )	Other Phone Number ( )

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. I consent to receive text messages and/or email messages from the practice to any cell number and/or email provided which may include appointment reminders, bills, payment receipts, or marketing materials. I understand that a patient's care is directed by his/her physician(s) and I consent to any services that are appropriate for my care and as ordered by my physician(s).

_____ Patient/ Guardian Signature

_____ Date

Consent to Obtain External Prescription History

- I authorize Georgetown Family Physicians Express Care (G.F.P. Express Care) to view my child's external prescription history via the RX Hub service.
- I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

Parent Signature: _____ Date: ____/____/_____

TRAVEL QUESTIONNAIRE

Have you traveled outside of the country within the last 30 days? Yes__No__
Have you had any direct contact with an ill individual who has traveled outside of the country within the last 30 days? Yes__No__

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Authorization for Consent to Treat a Minor

Name of Minor: _____ Date of Birth: _____/_____/_____
(First Name, Middle Initial, Last Name) (mm) (dd) (yyyy)

I, _____, as the Parent/Legal Guardian of the above-named minor, do hereby authorize: (**CHECK ONE IF APPLICABLE**)
(Printed Full Name of Parent or Legal Guardian)

☐ Minor named above to be seen on his/her own behalf. (Minor must be at least 16 years of age)

☐ Designated individual(s) listed below (must be 18 years of age or older) to bring the above-named minor to Georgetown Family Physicians Express Care (G.F.P. Express Care) as well as sign for Consent to Treat, Financial Policy and Consent to Obtain External Prescription History.

_____ _____ _____
(Printed Full Name of Individual Authorized to Consent) (Relationship) (Contact Phone Number)

_____ _____ _____
(Printed Full Name of Individual Authorized to Consent) (Relationship) (Contact Phone Number)

This authorization shall be limited to the following time period: _____ to _____
if no time period is designated, this authorization shall terminate one year from today's date.

Signature: _____ Date:_____
(Signature of Parent or Legal Guardian)

Parent/Legal Guardian Verbal Consent

Name:_____ Phone:_____ Date of Birth:_____

ECC Staff Signature (1):_____ Date:_____

ECC Staff Signature (2):_____ Date:_____

Verbal consent must be witnessed and signed by two ECC staff members. Name, phone number and DOB of consenting guardian must be recorded. Additionally, guardian must verify minor's name, address and DOB prior to authorizing consent. –ECC Management Team

Georgetown Family Physicians
EXPRESS CARE

HIPAA ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under law. You have the right to review our Notice before signing this acknowledgement. The terms of our Notice may change; if we change our notice you may request a revised copy by contacting our office or you will receive a new notice the next time you are treated at our office.

The practice provides this form to comply with the Health Information Portability and Accountability Act of 1996. (HIPAA)

The patient understands that:

- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice
- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice reserves the right to change the notice of privacy practices.

Please list names of individuals that we may *talk* to about your treatment. Please note this does not allow these individuals to obtain copies without a complete and valid authorization from the patient.

_____

_____

I acknowledge receipt of the Notice of Privacy Practices.

_____ _____
Printed Name of Patient or Representative Signature of Patient or Representative

_____
Date

Relationship to Patient (if other than patient) _____

□Check if patient refused to take a copy of the Notice of Privacy Practices

State reason for refusal, if known:

_____ _____
Witness (Staff) Signature Witness (Staff) Printed Name

_____
Date

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

- I authorize GFP Express Care to view my external prescription history via the RX Hub service.
- I understand the prescription history from multiple other unaffiliated medical providers, insurance companies and pharmacy benefit managers may be viewable by the providers and staff here, and it may include prescriptions back in time for several years.

Patient Signature :_____ Date:_____

Georgetown Family Physicians
EXPRESS CARE

FINANCIAL POLICY

Thank you for choosing us as your health care provider. The following is our Financial Policy. Our main concern is you receive the proper and optimal treatment needed to restore and maintain your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask our staff.

1. Your insurance will be filed as a courtesy to you; however you are responsible for the entire bill. **All co-payments, unmet deductibles and other patient responsible services must be paid at the time of the visit.** If your insurance carrier applies the billed charges to your deductible, denies the services, or considers the services non-covered, you are responsible for payment of the service. **If you do not have insurance, payment in full will be expected at the time of the visit.**
2. In the event your insurance company does not pay the claim within a reasonable amount of time (45 – 60 days) then you may become responsible for the bill. If payment is not received within a reasonable amount of time from the guarantor, or if we receive returned mail as undeliverable, we will place your account with an outside collection agency.
3. If your insurance plan requires a referral or prior authorization, you must present this along with your insurance ID at each visit. If you do not have the referral when you arrive for your appointment, payment for the visit becomes your responsibility.
4. Returned checks will be subject to a returned check fee. A fee may be charged for missed appointments.
5. **PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUESTS:** I certify the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I request that payment of assignment benefits be made on my behalf.
6. **FINANCIAL AGREEMENT:** The undersigned in consideration of the services to be rendered to the patient is obligated to pay the medical practice in accordance with its regular rates and terms, and if the account is referred to an attorney or agency for collections, to pay reasonable attorney's fees and collection expenses. The undersigned hereby assigns to the medical practice all insurance benefits for services provided. The undersigned agrees to be responsible for charges not covered by insurance. It is understood the obligation to pay the practice may not be deferred for any reason, including pending legal actions against other parties to recover medical costs.
7. **CONSENT FOR ROUTINE TREATMENT** I hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my physician(s) at **GFP ECC/Marisol Clark**. I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician(s). I understand that my medical care may require the collection of samples, including fluids or tissues, from my body. This may include having blood drawn or tissues removed during tests, treatment, or surgery. Further, I understand that should any hospital or emergency medical personnel, physician, or other person(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including Hepatitis Band C as well as HIV/AIDS. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examination at **GFP ECC**. I have the right to refuse tests or treatment (as far as the law allows) and to be told what might happen if I do. I have the right not to have any photos or videos taken of me unless I agree to this, except as needed to treat me.
8. **ELECTION TO ELECTRONICALLY TRANSMIT MEDICAL INFORMATION AT DISCHARGE:** I authorize Hospital to provide a copy of the medical record of my treatment, the discharge summary, and a summary of care record to my primary care physician(s), specialty care physician(s), and/or any health care provider(s) or facility(ies) identified on my discharge paperwork to facilitate my treatment and continuity of care. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. The summary of care record consists of information from my medical record, including among other things, information concerning procedures and lab tests performed during this admission, my care plan, a list of my current and historical problems, and my current medication list. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire automatically one year after the date on which my current treatment episode comes to an end.
9. **ADVANCE DIRECTIVE:** □ I have executed an Advance Directive □ I have not executed an Advance Directive

I have read and fully understand the Financial Policy and have been given the opportunity to ask questions.

_____ _____

Signature of patient, legal representative for health care services Date
If other than patient:

_____ _____

Relationship of Representative Reason individual is unable to sign, i.e. minor or legally incompetent

TAKING CHARGE OF YOUR HEALTH THROUGH

PATIENT PORTAL

Upon registering with Patient Portal an email will be generated by your physician practice and sent to the email address you specified during enrollment. This email will contain your user ID and password you will need to login into Patient Portal. Once logged in, you will be prompted to enter your date of birth and the phone number that is on file with your clinic. You will then be prompted to change your password and setup a security question. If you do not receive an e-mail within 24 hours please contact your clinic. Be sure to check your "junk" e-mail box.

What do I do if I have password or login problems?

- If you forget your password please click the "Forgot Password Button" on the website link and follow the on-screen instructions.
- If you forget your login ID, please call or visit your clinic and they can provide your login ID. If you get locked out of the Patient Portal, please contact your clinic so they can unlock your account.

What do I do if I cannot access the website?

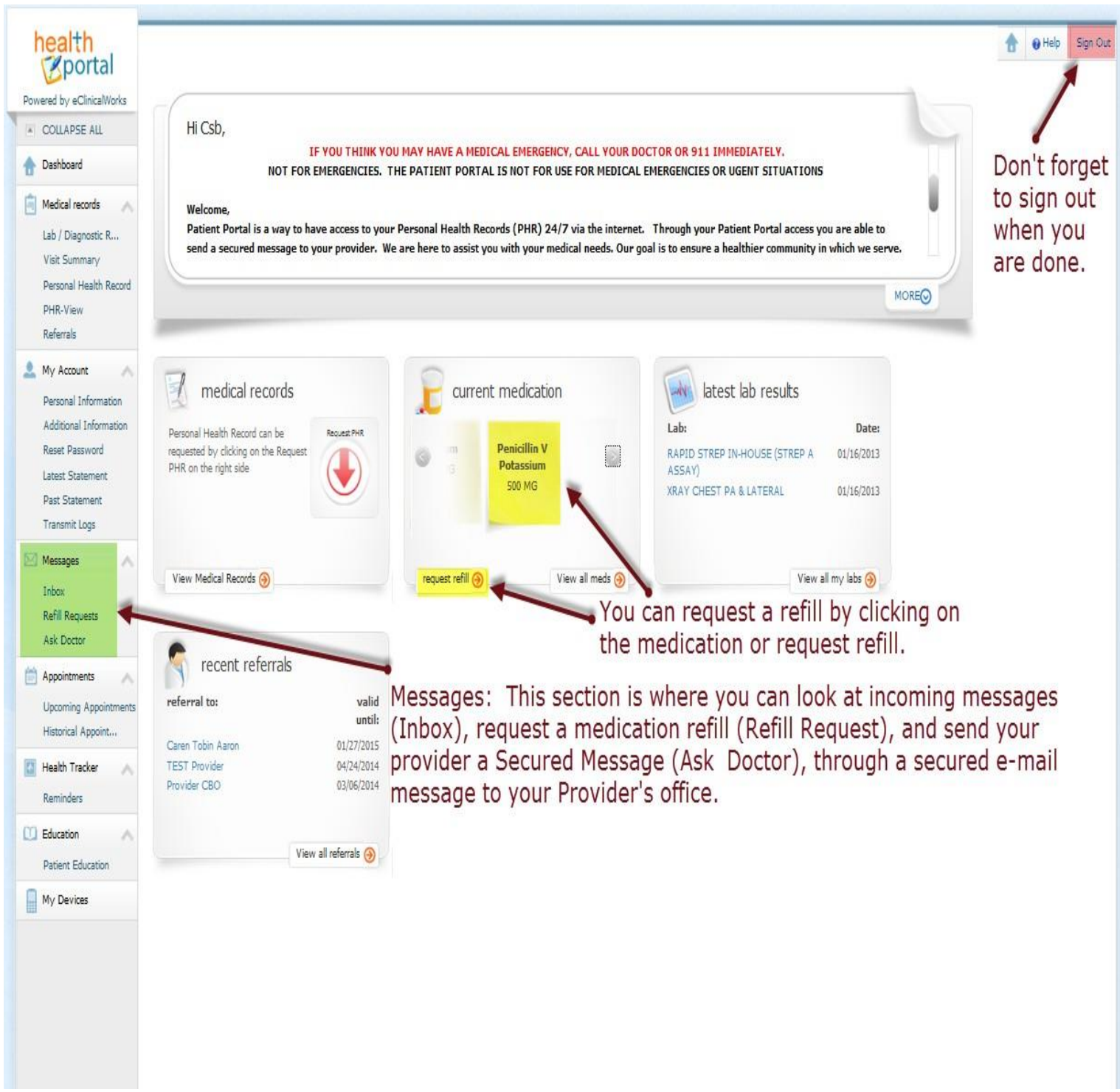
- First, verify that your internet is working by going to a common website, such as google.com or yahoo.com.
- If you cannot access any website, contact your Internet Service Provider.

If you cannot access the Patient Portal website but can access other websites, please call your practice.

If you have questions about what information is in your Personal Health Record (PHR), please contact your practice.

Tip: *Check your Spam folder and make sure to allow all emails from reminders@eclinicalmail.com.*

WHAT YOU CAN DO THROUGH YOUR PATIENT PORTAL



Georgetown Family Physicians

EXPRESS CARE

OFFICE POLICIES

*****Please be prepared to present your insurance card(s) at each visit.*****

It is essential that you provide all the necessary information about your insurance, both primary and secondary. Since changes in insurance coverage are frequent, it is our policy to obtain a copy of your card(s) for applicable insurance.

Our clinic offers our patients easy and private access to their medical information online via our Patient Portal. You can view your personal health record and send secure messages to the provider. To gain access to our secure server on Patient Portal and become web-enabled, simply sign-up by providing us with a personal (non-work) e-mail address.

Lab & Test Results

Our office utilizes LabCorp. It is our policy to inform patients concerning every test (X-ray or blood work) ordered through our office. If you do not hear from us within 7 days, please call us at (502) 570-3785 and ask about your results.

Prescription Refills

Please call your pharmacy directly for refill requests. If calling the office, please call only once. Please be aware that refills may take up to 24 HOURS to process, so please plan accordingly.

Forms and Letters

Please allow 5-7 working days for the completion of any forms or letters. Please be aware that any form brought to be completed may require a visit. Forms may not be faxed or mailed in. There is a $15 form fee for all FMLA & Short/Long Term Disability forms. This is a non-covered service and not payable by insurance. This amount is due at the time the forms are submitted to our office.

Late Policy

If you arrive more than 15 minutes late for your appointment, you may be asked to reschedule.

No-Shows

If you are unable to make your scheduled appointment, please contact the office 24 hours or as soon as possible. Your cancellation allows us to serve patients who have otherwise not been seen. If you do not cancel in advance and do not present to the office for your appointment, this is considered a “No show” appointment. This office reserves the right to dismiss a patient from the practice after three consecutive missed appointments in a 12 month period.

Medical Records:

A Medical request form must be filled out completely and signed by the patient or legal guardian.
Medical Records released to a new provider, specialist or school for continuity of care will be forwarded to the requesting facility at no charge. Medical records released to the patient (first copy is free) or requested by outside agencies will be charged a medical records fee of $25 for 1 – 25 pages and then an additional $1 per page for each page after the first 25 (maximum $50)

For Office Use Only:
Verified: Yes / No By: _____
D.Lic #: _____
SS #: _____
Signature: Yes/No

Georgetown Family Physicians
EXPRESS CARE
1502 Oxford Drive, Suite 100
Georgetown, KY
(502) 570-3785

AUTHORIZATION FOR PARENTAL ACCESS TO PATIENT PORTAL

SECTION A:

Patient's Name: _____**Medical Record #/ID number**: _____

Patient's Date of Birth: _____/ _____/ _____ (mm/dd/yyyy)

I hereby authorize **GFP EXPRESS CARE CLINIC** to use/disclose my individually identifiable health information in the manner described within this authorization. I understand that this authorization is voluntary and that if the person or entity authorized by this document is not a health plan or health-care provider that my information may no longer by protected from further disclosure by state or federal law.

List the purpose of the request for which the medical information is needed:

❑ **Yes,** Parental access to patient portal

Printed Parents Name: _____

Parent's Email Address: _____

SECTION B: (Patient must read and complete information in this section)

- _____I understand my health care will not be affected if I do not sign this form
- _____I understand that this authorization will expire on ____/____/____ (18th Birthday)
- _____I understand that I may revoke this authorization at any time by notifying [enter facility/practice name] in writing, except to the extent that has already taken in reliance of the previous authorization period.
- _____I understand that I have the right to receive a copy of this information if I request it.
-
- _____I understand that unless restricted by individual state laws, that this information may contain information about HIV, AID, sexually transmitted disease, or mental health disorders.
- _____ I understand this authorization applies to (in accordance with 42 CFR part 2) records containing drug/alcohol abuse or therapist psychiatric notes.

I hereby authorize the use or disclosure of my individually identifiable health information as described above.

Signature of Patient ***Date***

Notice of **Privacy Practices**

This notice describes how medical information about you may be used and shared and how you can get access to this information. Please review it carefully.

Your **rights**

You have the right to:

- Get a copy of your paper or electronic medical record
- Provide us a written request to have your paper or electronic medical record corrected
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information. This is a list of certain disclosures other than treatment payment or healthcare operations where authorization was not required.
- Get a copy of this privacy notice
- Choose someone to act for you

Your **choices**

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition if they are involved in your care and treatment or ask about you by name
- Notify your primary care physician of services provided to you at the hospital
- Provide disaster relief
- Include you in a hospital directory unless you ask us not to
- Provide mental healthcare
- Market our services and sell your information with your permission or utilize it for fundraising purposes

Our **uses & disclosures**

We may use and share your information as we:

- Treat you
- Run our organization
- Seek payment for services provided to you
- Help with public health and safety issues
- Do research
- Comply with the law*
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Respond to requests from workers' compensation, law enforcement and other government agencies
- Respond to lawsuits and legal actions

* For more information, request an expanded version of our privacy policy.

Georgetown Community Hospital

Effective Date
12/19/2016

Organized Health Care Arrangement (OHCA)

This notice applies to all service areas of Georgetown Community Hospital as well as the doctors and other healthcare providers practicing at this facility who are part of our organized health care arrangement (OHCA). It also applies to:

Bluegrass Pediatrics and Internal Medicine - Georgetown, Central Kentucky General Surgery, Central Kentucky Oncology and Hematology, Central Kentucky Radiology, Central Kentucky Urology, Dialysis Clinic, Inc., ENT Associates of Central Kentucky, Gastroenterology and Hepatology of the Bluegrass, Georgetown Bariatrics & Advanced Surgical Services, Georgetown Cardiology, Georgetown Family Physicians, Georgetown Family Physicians Express Care, Georgetown Neurology & Neurodiagnostics, Georgetown Orthopaedics and Sports Medicine, Kentucky Anesthesia Services, Lexington Infectious Disease Consultants, PSC, P & C Labs and TeamHealth

Your **rights**

We are required by law to protect the privacy of your information and notify you of certain breaches of your information. We are providing this notice to you so that we can explain our privacy practices. We will follow the practices described in this notice or the current notice in effect. We reserve the right to change our policies and notice of privacy practices at any time. If we should make a significant change, we will revise this notice and post a new one. You can also request a paper copy of our notice at any time.

My HealthPoint is Georgetown Community Hospital's Patient Portal. It is an exciting program designed to improve your healthcare and make office visits easier and more convenient. We will disclose demographic, insurance and medical information (collectively, your "health information") to My HealthPoint so that it can be viewed by you. This information will be viewable by you and/or anyone with whom you share it, Relay Health (the My HealthPoint portal provider) and the LifePoint Health Support Center (HSC), acting as business associates of LifePoint Health. Relay Health and the LifePoint HSC have been engaged to maintain, secure, monitor and evaluate the operation of the My HealthPoint patient portal. Relay Health and the LifePoint HSC also will be able to access your health information only for the purposes stated.

Complaints

To file a complaint or report a concern or conflict, call the number listed below:

Georgetown Community Hospital

Privacy Officer - Belinda Newsted

(502) 868-1230

If you prefer to report an anonymous concern, you may call **1-877-508-LIFE (5433).** You also may send a written complaint to the United States Department of Health and Human Services (HHS) if you feel we have not properly handled your complaint. You can use the contact listed above to provide you with the appropriate HHS address. Under no circumstance will you be retaliated against for filing a complaint.

For More Information

Ask any patient registration representative to receive a comprehensive, detailed summary of our privacy practices.

GEORGETOWN
COMMUNITY HOSPITAL

Georgetown Community Hospital
1140 Lexington Rd, Georgetown, KY 40324
(502) 868-1100