VIDALIA
IMMEDIATE + PRIMARY CARE

122 Alice Coleman Drive Vidalia, GA 30474 Post Office Box 2324 Vidalia, GA 30475
Phone: 912.805.2273 Fax: 912.805.2274

The following information is required for your Medical Records and to meet Federal Government Guidelines.

Patient LEGAL Name (First, Middle, Last) _____

Patient Address: Mailing Address _____

Street Address _____

City _____ State _____ ZIP _____ Cell Phone ( ) _____

Home Phone ( ) _____ Email _____

Social Security _____ Date of Birth _____ Age _____

Employer _____ Employer phone _____

Employer Address _____

PLEASE CIRCLE: Gender: Male or Female
Relation status: Single – Married – Widowed – Divorced – Legally Separated
Race: White – Black or African American – American Indian – Other
Ethnicity: Hispanic or Latino – Not Hispanic or Latino – Refuse to report
Language: English – Spanish – Indian – Other
Do you have a Living Will: Yes or No

Responsible Party LEGAL Name (First, Middle, Last) _____

Address _____

City _____ State _____ ZIP _____ Cell Phone ( ) _____

Home Phone ( ) _____ Email _____

Social Security _____ Date of Birth _____ Age _____

Employer _____ Employer phone _____

Employer Address _____

Who can we release your information to (This will include your emergency contact)

Emergency Contact _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

X _____ _____

Signature of Patient/Legal Guardian (Must be 18 years of age or older) Date

AUTHORIZATION TO CHECK PRESCRIPTION HISTORY

I authorize the corporation of **Vidalia Immediate and Primary Care** to check my prescription history when deemed necessary.

✓ _____ _____
Signature of Patient Date

✓ _____ _____
Signature of Patient Representative/Legal Guardian Date

Pharmacy_____ **Location** _____ **Phone** _____

Please circle:
Tobacco Use: Nonsmoker - Current smoker - Previous smoker - Vape - Cigarettes/Smokeless Tobacco
Amount = Less than 1 ppd - 1 ppd - 2 ppd - more than 2 ppd
Alcohol Use: No use - Occasional/Social use - Daily use
Have you had a flu shot this year? YES or NO
Have you had a pneumonia shot this year? YES or NO

Current Medications

Date	Medication	Dosage
Date	**Drug Allergies**	**Reactions**

List any surgeries and/or serious conditions

Date	Surgery/Procedure	Hospital

DISCLOSURE TO FRIENDS AND/OR FAMILY MEMBERS

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below. I may revoke or modify this specific authorization at any time but it must be in writing.

Name	Relationship	Phone Number

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient/Legal Guardian *(Must be 18 years of age or older)* Date:

CONSENT TO PROCEDURES AND TREATMENTS

This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). This consent provides us with your permission to perform reasonable and necessary medical examinations, that may include testing (for example, X-rays and blood tests), standard care (for example, intravenous fluids or injections), and evaluations (interviews and physical exams).

I understand that I may receive treatment and healthcare services given by **Vidalia Immediate and Primary Care** team members (such as nurse practioners, physician assistants, nurses and technicians).

I understand that **Vidalia Immediate and Primary Care** participates in clinical education programs with area colleges and universities to give students engaged in a course of study related to a medical career; including nursing students, medical students, interns and residents ("students") experience in clinical practice. Your physician has agreed to permit such students to observe and participate in his/her patient care activities, including, where appropriate, providing medical care to patients under the physician's direct supervision.

I understand that I retain no property rights to any tissue samples or bodily fluids removed from my body (specimens) as part of procedures or treatment given to me. I further understand that **Vidalia Immediate and Primary Care** has no obligation to preserve these specimens; that it will retain or dispose of specimens according to its usual practices.

I understand that **Vidalia Immediate and Primary Care's** practice is to convey test results to patients by phone, mail (to the address provided by the patient or caregiver) or in person. I understand that the clinic's policies do not permit discussions about my health information, or transmission of my test results via email, since email is generally not a secure method of communication. I understand that I always have the option to call the clinic or make an appointment to come in to discuss my test results or health issues with a provider.

I understand I have the right to discuss the treatment plan with my physician about the purpose, potential risks and benefits of any test ordered. If I have any concerns regarding any test or treatment recommend by my health care provider, I am encouraged to ask questions.

_____ _____

Signature of patient/legal guardian (must be 18 yrs of age or older) Date

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NO SHOW/LATE CANCELLATION POLICY

It is necessary for us to make appointments in order to see our patients as efficiently as possible. No-shows and late-cancellations cause problems that go beyond a financial impact on our practice. When an appointment is made, it takes an available time slot away from another patient. No-shows and late-cancellations delay the delivery of healthcare to other patients, some who are quite ill.

As our practice continues to grow, we have updated our cancellation policy in order to better serve our patients. Your appointment time is reserved especially for you. Please call 912-805-2273 at least **72 hours** before your scheduled appointment if you will be unable to keep your appointment. This allows Dr. Foust to offer that appointment to another patient who needs medical care.

If you do not cancel your appointment at least 72 hours in advance, you will be charged a no-show or late cancellation fee of $30.

We understand that situations such as medical emergencies occasionally arise. These situations will be considered on a case by case basis.

Please understand that insurance companies consider this charge to be entirely the patient's responsibility.

✓ _____

Signature of Parent/Legal Guardian

✓ _____

Date

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Statement of Non-Payment

I,_____acknowledge the fact that I have been informed that Vidalia Immediate & Primary Care is not contracted with **MEDICAID**. Therefore, I am responsible for any balances not paid by my primary insurance carrier.

By signing below you acknowledge that you will be financially responsible for any unpaid balance by your primary carrier. If you have any questions, please give our office a call at (912) 805-2273.

✓ _____

Signature of Patient/Legal Guardian *(Must be 18 years of age or older)*

✓ _____

Date

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CONSENT TO TREATMENT of a MINOR

Child's **LEGAL** Name (first, middle, last)_____

Child's Date of Birth _____

The undersigned parent or legal guardian of the above named child authorizes the person(s) listed below to consent to treatment of the child, including, but not limited to, emergency, x-ray, anesthetic, or surgical services when they are not immediately available in person, or by telephone call to (phone number)_____.

It is understood that this consent is given in advance of any specific diagnosis or treatment and allows the physician/provider to diagnose and treat the child even when the parent or guardian is not present.

Person(s) other than parent/legal guardians who may consent to treatment:

Name _____ Phone _____ Relationship to child _____

Name _____ Phone _____ Relationship to child _____

Medical Concerns:_____

Known Allergies:_____

Name of Parent or Legal Guardian _____

Relationship to child_____

Contact Number(s)_____

✓ _____

Signature of Parent/Legal Guardian

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HIPAA 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. If you have any questions about this notice, please contact our office at 912.805-2273.

OUR OBLIGATIONS

We are required by law to:

- Maintain the privacy of Protected Health Information (PHI)
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

PHI includes information that we create or receive about your past, present, or future health or condition, the provision of health care to you, or the payment for health care provided to you. In general, we may not use or share anymore PHI than is necessary to accomplish our purpose.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our Practice Administrator.

- **Treatment:** We may use and disclose PHI for your treatment and to provide you with treatment-related health care services. For example, we may disclose PHI to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.
- **Payment:** We may use and disclose PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may share PHI with your health plan to obtain approval for the health care services we provided to you. We may also share PHI with billing companies and companies that process our health care claims.
- **Health Care Operations:** We may use and disclose PHI for health care operation purposes.

These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the care you receive is of the highest quality. We may also share information with our accountants, attorneys and others in order to make sure we are complying with the laws that affect us.

OTHER USES OF PHI

- **Reports required by law:** We may report PHI when the law requires us to give information to government agencies and law enforcement about victims' of abuse, neglect, or domestic violence; when dealing with gunshot and other wounds, or when required in a legal proceeding.
- **Public health:** We may report PHI about births, deaths, and other diseases to government officials in charge of collecting that information. We may provide PHI relating to death to coroners, medical examiners, and funeral directors.
- **Health oversight:** We may report PHI to assist the government when it investigates or inspects a health care provider or organization.
- **Organ Donation:** We may notify organ banks to assist them in organ, eye, or tissue donation and transplants.
- **Research:** We may use PHI in order to conduct medical research.
- **To avoid harm:** We may report PHI to law enforcement, in order to avoid a serious threat to the health or safety of a person or the public.
- **Other government functions:** We may report PHI for certain military and veterans' activities, national security and intelligence purposes, protective services for the President of the United States, or correctional facility situations.
- **Workers' compensation:** We may report PHI in order to comply with workers' compensation laws. • Appointment reminders and health-related benefits or services: We may use health information to give you appointment reminders; or give you information about treatment choices or other health care services or benefits we offer.
- **Inmates or individuals in custody:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information to the correctional institution or law enforcement official. This release would be made necessary if: 1) for the institution to provide you with health care: 2) to protect your health and safety or the health and safety of others: 3) for the safety and security of the correctional institution.

Your Rights

You have the following rights regarding health information we have about you:

- **Your rights to request limits on our use of PHI:** You may ask that we limit how we use and share you PHI. We will consider your request but are not legally required to agree to it. If we agree to your request, we will follow your limits, except in emergency situations. You cannot limit the uses and reports that we are legally required or allowed to make. To request a restriction, you must make your request in writing to the Practice Administrator.
- **Right to Request Confidential Communication:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communication, you must make your request in writing to the Practice Administrator. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.
- **Your right to view and get a copy of your PHI:** You may view or obtain a copy of your PHI (except for mental health notes). Your request must be in writing. We will reply to you within 30 days of your request. If you request a copy of your PHI, we may charge a fee. Instead of providing the PHI you requested, we may offer to give you a summary or explanation of the PHI, as long as you agree to that and to the cost in advance.
- **Your rights to a list of the reports we have made:** You have the right to get a list of the parties to whom we have reported you PHI. The list will not include reports for treatment, payment, or health care operation; reports you have previously authorized: reports made directly to you or to your family; reports made for national security purposes; reports to corrections or law enforcement personnel; or reports made before April 14, 2003.

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• **Your rights to a list of the reports we have made:** You have the right to get a list of the parties to whom we have reported you PHI. The list will not include reports for treatment, payment, or health care operation; reports you have previously authorized: reports made directly to you or to your family; reports made for national security purposes; reports to corrections or law enforcement personnel; or reports made before April 14, 2003.

• **We will respond to your request within 60 days:** we will include the reports made in the last six years unless you request a shorter time. The list will include the date of each report, the identity of the person (s) receiving the report, the type of information reported, and the reason for the report.
• **We will not charge you for the list:** If you make more than one request in the same year, however, we may charge you a fee for each additional request. For a list, you must make a request in writing to the Practice Administrator.
• **Your right to correct or update you PHI:** If you feel that there is a mistake in your PHI, or that important information is missing, you may request a correction. Your request must be in writing and include a reason for the request. Your request must be made to the Practice Administrator. We will respond within 60 days of your request. We may deny your request if the PHI is, 1) correct and complete, 2) not created by us, 3) not allowed to be shared with you, or 4) not in our records. If we deny your request, we will inform you of the reason for the denial. You may then file a written statement of disagreement, or you may ask that your original request and our denial be attached to all future reports of your PHI. If we agree to honor your request, we will change your PHI, inform you of the change, and tell any others that need to know about the change to your PHI.
• **Your right to a paper copy of this notice:** You can ask us for a copy of this notice at any time.
• **Person to contact for information about this notice or to file a complaint about our privacy practices:** If you have any questions about this notice, wish to file a complaint about our privacy practices, feel that we may have violated your privacy rights, or disagree with a decision we made about access to your PHI, please contact our Practice Administrator. You may also send a written complaint to the Secretary, U.S. Department of Health and Human Services, 2003 Independence Avenue, S.W., Washington, D.C. 20201. Your complaint will not alter or affect the care we provide to you.
• **Effective date of this notice:** this notice is in effect as of November, 2021.

CONSENT TO TREAT I hereby consent and authorize the performance of all appropriate procedures and courses of treatment, the administration of all anesthetics, and any and all medications which in the judgment of my provider may be considered necessary or advisable for my diagnosis and/or treatment.

FINANCIAL RESPONSIBILITY I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at Vidalia Immediate & Primary Care. I am responsible for any applicable deductible, co-insurance or co-payments prior to the provision of services. Vidalia Immediate & Primary Care will provide me with an estimate of my total financial responsibility and the date by which this amount must be paid in full. In the event my care exceeds the amount of the estimate, I will be financially responsible for the balance. I further understand that such payment is not contingent on any insurance, settlement or judgment payment. Vidalia Immediate & Primary Care may file a claim for payment with my insurance company as required by contractual agreement. If the insurance company fails to pay Vidalia Immediate & Primary Care in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts owed to Vidalia Immediate & Primary Care. Should the account be referred to a collection agency or attorney for collection, the undersigned shall pay all costs of collection, including but not limited to court cost and 15% attorney's fee.
RESPONSIBILITY TO PROVIDE PROOF OF INSURANCE I understand that it is my responsibility to provide Vidalia Immediate & Primary Care with a copy of **my current insurance card**. If I do not have insurance, I will be considered a Private Pay (or Self Pay) patient and I am financially responsible for the total amount of the services provided. I will notify Vidalia Immediate & Primary Care immediately upon any change in my insurance.

ASSIGNMENT OF BENEFITS I hereby authorize and assign all payments and/or insurance benefits for medical services and procedures rendered to patient, directly to Vidalia Immediate & Primary Care. I hereby authorize Vidalia Immediate & Primary Care to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by my insurance plan.

INSURANCE WAIVER , NON-COVERED SERVICES WAIVER and OUTSIDE LAB SERVICES
I understand that if I do not have a copy of a current insurance card and valid referral, if required, Vidalia Immediate & Primary Care is not obligated to see me. Without proof of insurance, I agree to pay the total cost in advance. I agree that neither Vidalia Immediate & Primary Care nor I will file a claim for the visit. I will be required to pay the total cost of the visit in advance. In addition, there may be a service I desire, suggested or provided that is not covered under my insurance plan ("Non-Covered Services"); I understand I must pay for "Non-Covered" services. If feasible, a waiver will be completed for each "Private Pay" visit or "Non-Covered Service." I understand services sent to an outside lab are billed to my insurance or me by the lab and I will receive a separate invoice from the lab.
ANNUAL EXAMS (Including Medicare Annual Visits)
Annual Wellness Exams are preventive visits and are very important in developing a personal health strategy. Most Insurance companies allow one annual wellness exam per year. All patients of Vidalia Immediate & Primary Care must have their Annual Wellness Exam performed at this facility each year. I understand this is very important as Vidalia Immediate & Primary Care strives to develop a strategy to manage my long term health. I realize this strategy can help maintain or improve my overall health which in turn may reduce "sick visits" and hospitalization. Therefore, Annual exams do not include "sick" problems I may be having – as insurance companies classify these visits as "sick visits." If I am experiencing problems, the office may be required to change the visit type per insurance requirements and reschedule the Annual Wellness Exam.
ADDITIONAL INFORMATION
Vidalia Immediate & Primary Care accepts payments in: Cash, Check, Debit and Credit Cards. I understand additional charges are applied to my account for any returned checks used to pay on my account, for certified letters sent to me for collection on my account and collection agency fees. I may also be charged if I do not cancel my scheduled appointment, for not paying my co-pay and/or co-insurance or patient responsibility including deductible at the time of service, for telephone management services, for educational materials, for payment agreements which extend beyond 3 months, and for other administrative expenses not covered by my insurance plan. In the event I receive payment from my insurance carrier, I agree to endorse any payment due for services rendered to Vidalia Immediate & Primary Care. This office utilizes the services of physician assistant/nurse practitioner. Patients will alternate appointments between the physician and physician assistant/nurse practitioner so each provider will be familiar with all patients. Appointments may be moved to another provider in the event of an emergency or to reduce a prolonged wait time.

I acknowledge that I have received the practice/clinic's Notice of Privacy Practice/clinics, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice/clinic's Notice of Privacy Practice/clinics.

_____	_____	_____
Printed Name	Signature	Date

INSURANCE AUTHORIZATION AND TREATMENT REQUEST

I authorize the corporation of **Vidalia Immediate and Primary Care** to release any information concerning the treatment for my dependent(s) or myself. I assign **Vidalia Immediate and Primary Care** any benefits normally payable to me to be PAID DIRECTLY TO THE PRACTICE for all services rendered. I permit a photocopy of this authorization to be used in place of the original. I recognize and ACCEPT responsibility for any balances or fees not covered by my insurance carrier. I request and consent to treatment and promise to pay for services and material furnished, to include upto a $250.00 collection fees plus attorney fees if unpaid balance is forwarded into collection status.

Primary Insurance

Name of Insurance _____

Policy/Member ID Number _____

Group/Plan Number _____

Policy Holder Name and Date of Birth _____

Policy Holder Relationship to Patient _____

Secondary Insurance

Name of Insurance _____

Policy/Member ID Number _____

Group/Plan Number _____

Policy Holder Name and Date of Birth _____

Policy Holder Relationship to Patient _____

OFFICE PAYMENT POLICIES

COPAYS, NOT YET MET DEDUCTIBLES AND/OR CO-INSURANCE RESPONSIBILITIES ARE TO BE PAID WHEN SERVICES ARE RENDERED. IF OUR OFFICE IS NOT REQUIRED TO COLLECT WHEN SERVICES ARE RENDERED PAYMENT IS DUE WITHIN 14 DAYS OF RECEIVING YOUR STATEMENT.

*****There is a $35.00 service charge on all returned checks*****

We welcome all questions concerning your account. Thank You!

✓ _____

Signature of Patient *(Must be 18 years of age or older)*

✓ _____

Date

✓ _____

Signature of Patient Representative/Legal Guardian

✓ _____

Date