ATHENS NEIGHBORHOOD HEALTH CENTER ANHC

"Keeping Quality Healthcare in the Neighborhood."

Last Name: _____ First Name: _____ Middle Int: _____ Preferred Name: _____

Date of Birth: _____/_____/_____ Social Security #: _____ Preferred Language: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____ E-mail: _____

If patient is under 18, please provide guardian's information:

Last Name: _____ First Name: _____ Relation to Patient: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____ E-mail: _____

Would you like to access your medical records via the Internet/Patient Portal? O Yes, please provide email above O No

Gender Assigned at Birth: Choose One	**Relationship Status: (Choose One):**
O Male O Female	O Single O Married O Divorced O Separated O Widowed
Race: Choose All That Apply O American Indian or Alaskan Native O Asian O Black or African American O Native Hawaiian O Other Pacific Islander O White O Unreported/Refuse to report race	**Ethnicity: (Choose One)** O Hispanic or Latino O Non-Hispanic or Non-Latino O Refuse to report Ethnicity

In case of an emergency, who can we contact?

Last Name: _____ First Name: _____ Contact: _____

Preferred Pharmacy: _____ Telephone: _____

Financial Information: Athens Neighborhood Health is a Federally Funded Organization who must capture the financial status of its patient to continue receiving funding: **PLEASE ANSWER ALL THE QUESTIONS BELOW.**

Insurance Status: O Private Insurance O Medicare O Medicaid O Uninsured

Do you want to apply for fee discounts based on your household income and size? O Yes O No

HOUSEHOLD SIZE AND COMBINED YEARLY INCOME

Circle the range in relation to your family size that best describes your household income.

Members in Household	Household Income				
1	Below $15,960	$19,950	$23,940	$27,930	$31,920
2	Below $21,640	$27,050	$32,460	$37,870	$43,280
3	Below $27,320	$34,150	$40,980	$47,810	$54,640
4	Below $33,000	$41,250	$49,500	$57,750	$66,000
5	Below $38,680	$48,350	$58,020	$67,690	$77,360
6	Below $44,360	$55,450	$66,540	$77,630	$88,720
7	Below $50,040	$62,550	$75,060	$87,570	$100,080
8	Below $55,720	$69,650	$83,580	$97,510	$111,440

Insurance Plan Name:

Policy Holder (if other than patient)

Last Name: _____

First Name: _____

Birth Date: _____/_____/_____

Gender: O Male O Female

Policy Information

Patient Relationship to Policy Holder: _____

ID No.: _____

Policy/Group No: _____

Employer Name: _____

Secondary Insurance Plan Name:

Policy Holder (if other than patient)

Last Name: _____

First Name: _____

Birth Date: _____/_____/_____

Gender: O Male O Female

Policy Information

Patient Relationship to Policy Holder: _____

ID No.: _____

Policy/Group No: _____

Employer Name: _____

ASSIGNMENT, RELEASE, AND CONSENT

- I hereby authorize Athens Neighborhood Health Center, to furnish information to insurance carriers concerning my illness and treatment. I acknowledge that the above information is true and accurate demographic information for the patient listed on this registration form.
- I acknowledge Athens Neighborhood participate with health record sharing networks for care coordination, and I give my consent.
- I authorize the physician to release any medical information required to process claims.
- I consent to receive treatment from a Physician Assistant or Advanced Practice Nurse working under the supervision of an Athens Neighborhood Physician.
- I understand 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 Athens Neighborhood Health Center. I understand that I cannot be turned away for Title X services for inability to pay.
- I understand that an HIV test is included as part of standard preventative screening test, and that I may decline having the test performed at any time.
- 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 consent to using telehealth services including secure video, audio, or messaging, for healthcare services, which may include consultation diagnosis and treatment. I agree to be a in a private, quiet, and safe location for my telehealth session and will not record the visit without my provider's permission.
- I understand that my financial responsibility for telehealth services will be determined by my insurance plan and that I am responsible for copayments or fees not covered by my insurance.

I certify that all information provided by me is accurate.

Signature _____ Date: _____

O Patient O Parent O Guardian

PATIENT-PROVIDER AGREEMENT

Athens Neighborhood is recognized as a Patient-Centered Medical Home (PCMH), a model dedicated to enhancing overall patient health and helping individuals achieve their personal health goals. In this approach, each patient is supported by a comprehensive care team that may include a primary care physician, specialists, dietitians, nurses, medical assistants, case managers, and other professionals based on the patient's unique needs. Athens Neighborhood is committed to ensuring that the right team of healthcare providers is assembled to offer personalized, coordinated care for every patient.

Patient or Parent/Guardian Responsibilities

As our patient, your responsibilities are:

- Make every effort to attend scheduled visits, or reschedule them in advance whenever possible.
- For any non-emergency issues, reach out to our office before seeking outside care.
- If you are admitted to a hospital or visit the emergency department, please inform our office as soon as possible.
- Actively participate in developing and following your care plan. If you're unable to meet the goals set, let your provider know so we can adjust the plan accordingly.
- Educate yourself about preventive care, as we believe a healthy family fosters a healthy patient.
- Be aware of your insurance coverage and your financial obligations. We kindly request that co-pays and sliding scale fees be paid at the time of service.

Provider Responsibilities

Your health and well-being are our top priorities, and we are committed to supporting you every step of the way.

- Delivering safe, high-quality care in the language of your choice.
- Ensuring 24-hour access to medical care, including same-day appointments whenever possible.
- Coordinating your care with other healthcare providers through referrals and collaboration.
- Protecting your privacy -your medical information will not be shared without your consent.
- Providing clear instructions for managing your healthcare needs when our office is closed.
- Concluding each visit with clear guidance on expectations, treatment goals, and next steps.

Patient Scheduling Expectations

- As a courtesy to our patients, we provide reminder calls and other important notifications, which may include prerecorded messages or text messages.
- If you arrive 15 minutes or more after your scheduled appointment time, we reserve the right to reschedule your appointment for a later time or another day that works for you.
- If a patient misses three (3) consecutive appointments within a 12-month period, we may no longer schedule future appointments in advance. However, the patient will still have the option to be seen as a walk-in for same-day appointments, subject to availability.

Signature of Patient or Legal Guardian: _____ Date: _____

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

Patient Name _____ Patient Date of Birth: _____/_____/_____

Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, healthcare providers must inform individuals about how their health information is used, shared, and protected. This notice outlines the ways in which medical information may be utilized, including for treatment, payment, and healthcare operations, such as sharing data with other providers or insurance companies. It also details certain circumstances where health information may be disclosed without consent, such as in emergencies or to comply with legal obligations. Individuals have specific rights over their health information, including the right to access, amend, or restrict its use, as well as to receive communication in their preferred manner. If you believe your privacy rights have been violated, you have the right to file a complaint.

To request limitations and restrictions, you must complete this form and return it to us. Please describe specifically as possible the type of information that you would like for us to restrict or limit and how you would like this information to be restricted or limited.

○ All information in EHR ○ Appointments ○ Diagnostic Test Results

May only share with:

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

Signature of Patient or Guardian: _____ Date: _____

Patient Rights and Responsibilities

The Mission of the Athens Neighborhood Health Center is to provide affordable, high quality healthcare to all individuals in Athens-Clarke County and surrounding areas. We strive to work with our patients and their families to provide the highest quality of care. We want to ensure all of our patients are aware of their rights and responsibilities in efforts to support their wellbeing of their healthcare needs.

YOU HAVE RIGHT TO:

- Patients have the right to receive care that is respectful and considerate of their values, beliefs, and personal preferences, without discrimination.
- Patients have the right to be fully informed about their diagnosis, treatment options, and prognosis, in a manner that they can understand.
- Patients have the right to privacy and confidentiality regarding their medical records and health information, in accordance with applicable laws (e.g., HIPAA in the U.S.).
- Patients have the right to actively participate in decisions about their treatment plan, including the right to refuse or discontinue treatment (within the limits of the law).
- Patients are entitled to receive care that is safe, appropriate, and consistent with current medical standards, and to be free from abuse, neglect, or exploitation.
- Patients have the right to receive appropriate pain assessment and management based on their individual needs.
- Patients have the right to receive information in a language they understand, including the right to have an interpreter if necessary.
- Patients have the right to voice concerns or complaints about the care they are receiving, and to have those concerns addressed in a timely manner.

YOU HAVE A RESPONSIBILITY TO:

- Patients are responsible for providing accurate and complete information regarding their health history, current conditions, medications, and any other relevant details that could impact their care.
- Patients are expected to actively participate in their treatment plan and follow instructions from healthcare providers, including medication schedules and lifestyle modifications.
- If a patient does not understand their diagnosis, treatment options, or instructions, they should ask questions to ensure clarity.
- Patients should make every effort to keep scheduled appointments and, if they are unable to do so, notify the healthcare facility in advance.
- Patients are responsible for maintaining a safe environment for themselves and others, including complying with facility policies (e.g., smoking, alcohol, and drug use).
- Patients should treat healthcare providers, staff, and fellow patients with courtesy and respect, recognizing that healthcare is a collaborative process.
- Patients are responsible for understanding their insurance coverage and paying for services rendered, as applicable.

If you have questions, concerns or comments, please request to speak to the Site Manager. If you feel your question or concerns has been unresolved, please contact the Compliance Officer at either ANHCCorporateCompliance@aneighbor.org or 706-850-9041 ext. 6962

Signature of Patient or Guardian:_____ Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION INCLUDING ANY SUBSTANCE USE DISORDER RECORDS 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 uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure 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. We must obtain your authorization before the use and disclosure of any psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosure that constitute a sale of PHI. Uses and disclosures not described in this Notice of Privacy Practices will be made only with authorization from the individual.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive at the Center 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 an 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 Center or the hospital. For example, we may disclose medical information about you to people outside the Center 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 Center and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other Center personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

NOTE: Use and disclosures described above as they relate to Substance Use Disorder ("SUD") records require your specific consent at the bottom of this form before we can utilize them for treatment, payment or healthcare operation purposes ("TPO"). You can sign one form to permit all future uses and disclosure for TPO purposes or you can restrict your consent to each individual disclosure. Examples of how your SUD information is used or disclosed upon our consent is consistent with the examples set out above. You should be informed that the requirement for your consent for TPO is specific to us. Once any SUD records are released to another HIPAA covered entity or business associate, they are permitted to redisclose records in accordance with HIPAA regulations.

Who Will Follow this Notice. This notice describes our Center's policies and procedures and that of any health care professional authorized 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 Center personnel.

Policy Regarding the Protection of Personal Information. We create a record of the care and services you receive at the Center. 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 Center, whether made by Center personnel or by your 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. Current law permits us to include any SUD records in your treatment record with other treatment therapies. **Other ways we may use or disclose your protected healthcare 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: coroners, medical examiners and funeral directors; health oversight activities; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; and others; public health risks; and worker's compensation.

**Other than releasing SUD records to a coroner or medical director without specific consent and to public health authorities, provided that the records disclosed are de-identified according to standards established in the HIPAA Privacy Rule, your written consent is required for the other types of disclosure mentioned above, i.e., research, fundraising, avert a serious threat to health or safety except in emergency situations, law enforcement, military and veterans, national security and intelligence activities, organ and tissue donations; and other public health risks and workers' compensation. Any SUD records may not be used as records and testimony in civil, criminal, administrative and legislative proceedings absent your written consent.

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.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the Center. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an 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 operations (SUD records require your specific written consent)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. Except as to SUD treatment, 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 Officer.

Right to Request Removal from Fundraising Communications. You have the right to opt out of receiving fundraising communications from the Center For any SUD related treatment, you must provide your written consent to be included in fundraising activities.

Right to Restrict Disclosures to Health Plan. You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment of health care operations and pertains to a health care item or service for which the individual has paid out of pocket in full. Disclosure of SUD records to a health plan require your written consent.

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 in writing, and you must specify how or where you wish to be contacted.

Right to an Accounting of Disclosures You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you (for SUD disclosures, your request can include the prior three years). To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer.

Changes to this Notice. We reserve the right to change this notice. We will post a copy of the current notice in the Center's waiting room. COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the Center or with the Secretary of the Department of Health and Human Services. To file a complaint with the Center, contact the Compliance Officer, 706-850-9041 or ANHCCorporateCompliance@aneighbor.org. 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 Officer.

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.

_____ _____

Signature Date