CURTIS V. COOPER PRIMARY HEALTHCARE, INC.

Registration and Financial Evaluation Records

Patient Information

Date of Registration / Time	Last Name	First Name	Middle Name	Account Number
SSN:	Date of Birth	Age	Sex	Slide Fee Scale/Review Date
Preferred Pharmacy?	Do you have an Advance Directive? Y O N O			Household Size #
Address / Apartment #	City, State, Zip			
Home Phone / Work Phone	Work Status:		Employer Name:	
Patient Email Address:	Marital Status:		Highest Level of Education:	

State your yearly gross income:

How often are you paid

- Weekly O
- Bi-Weekly O
- Semi-Monthly O
- Monthly O
- Annually O

What is your race?

- O American Indian or Alaska Native
- O Asian
- O African American
- O Native Hawaiian or Other Pacific Islander
- O White
- O Other

What is your ethnicity?

- O Hispanic or Latino or Spanish Origin
- O Not Hispanic or Latino or Spanish Origin

Additional Information:

Homeless	O Y N O
Migrant/Seasonal Worker	O Y N O
Public Housing	O Y N O
Veteran	O Y N O
Disabled	O Y N O

Please specify disability:

Demographic Information

Patient Gender:		Preferred Language
O Male	O Female	

Guarantor Information

Last Name	First Name	Middle Name	Date of Birth:
Relationship to Patient	Sex	Phone #	Account Number:
Address	Apartment #	City, State, Zip	Email Address:

Insurance Information

Primary Insurance Plan Name	Primary Policy # / Group #	Primary Subscriber Name/ DOB
Secondary Insurance Plan Name	Secondary Policy # / Group #	Secondary Subscriber Name/ DOB

Emergency Contact Information

Last Name:	First Name:	Middle Name:
Relationship to Patient:	Phone:	Date of Birth:
Address	City, State	Zip:

Patient Signature: _____ CVCPHC Employee: _____

Date: _____ Date: _____

Rev. 05/25

Notice of Privacy Practices

We are committed to protecting your personal health information in compliance with the law. The attached Notice of Privacy Practices states:

- our obligations under the law with respect to your personal health information
- how we may use and disclose the health information that we keep about you
- your rights relating to your personal health information
- our rights to change our Notice of Privacy Practices
- how to file a complaint if you believe your privacy rights have been violated
- the conditions that apply to uses and disclosures not described in this Notice
- the person to contact for further information about our privacy practices

We are required by law to give you a copy of this notice and to obtain your written acknowledgement that you have received a copy of this notice.

I consent to the use and disclosure of my Protected Health Information for treatment, payment and the operations of Curtis V. Cooper Primary Health Care, Inc.

You may communicate with the following individual regarding my condition or course of treatment Name_____

Address_____

_____

Telephone#_____

Relationship_____

Patient Acknowledgment of Receipt

I,_____ hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

_____

_____

Patient's Signature **Date**

811 MR 4/03

CURTISV. COOPER PRIMARYHEALTHCARE,INC.

GENERAL CONSENT FOR TREATMENT, RELEASE OF MEDICAL INFORMATION AND AUTHORIZATION FOR INSURANCE PAYMENT

1. I, the undersigned or legal guardian, grant permission as indicated below to undergo all necessary tests, treatments, and other procedures or studies required for the diagnosis by the medical staff and other employees of Curtis V. Cooper Primary Healthcare, Inc.

2. 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 treatment and examination by Curtis V. Cooper Primary Healthcare, Inc.

3. I consent to the release of medical information to other institutions or agencies accepting the patient for medical or institutional care, and consent to the release of medical information to patient's insurer and give permission to release data (both medical and personal) to such government agencies as is required of Curtis V. Cooper Primary Healthcare, Inc. by law, rules, regulations, or by consent.

4. I consent to the release of medical and financial information for auditing purposes.

5. I consent for my medical records to be shared electronically, securely, and confidentially through Chatham Health Link Exchange, HIE. I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

6. I hereby authorize payment to Curtis V. Cooper Primary Healthcare, Inc. of benefits due to me in my pending claim and/or MAJOR MEDICAL BENEFITS, otherwise payable to me, but not to exceed the health center and/or physician regular charges for this period of treatment. I agree that a copy of this authorization is as valid as the original. I understand that if my insurance does not approve the charges for this visit, I am fully responsible to Curtis V. Cooper Primary Healthcare, Inc. for payment.

7. MEDICARE PATIENTS ONLY: I authorize any holder of medical or other information about me to release to Centers for Medicare and Medicaid (CMS) or its intermediaries or carriers, any information needed for this or any subsequent Medicare claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party that accepts assignment for such claim.

8. I hereby voluntarily consent to treatment now and during all subsequent visits to the Curtis V. Cooper Primary Health Care, Inc. I apply for and voluntarily consent to such primary care, mental health, family planning services, including HIV/HCV testing, as may be ordered and/or recommended by physicians and/or appropriate designee responsible for my medical care. I further understand that if my healthcare providers recommend HIV/HCV testing as part of my medical treatment and/or care, I will have the opportunity to consent or refuse such testing at the time of the recommendation of HIV/HCV testing is discussed with me.

BY SIGNING THIS DOCUMENT, I ATTEST THAT ALL INFORMATION IS TRUE AND CORRECT AND I WILL NOTIFY CURTIS V. COOPER PRIMARY HEALTHCARE, INC. OF ANY CHANGES TO MY INSURANCE, INCOME, OR CONTACT INFORMATION.

Name of Patient (PLEASE PRINT)	CVCPHC Representative (PLEASE PRINT)
Signature of Patient or Legal Guardian	CVCPHC Representative's Signature

O.C.G.A. § 50-36-1 (e) (2) Affidavit

By executing this affidavit under oath, as an applicant for a(n) Health Benefits, as referenced in O.C.G.A. § 50-36-1, from CHATHM COUNTY, the undersigned applicant verifies one of the following with respect to my application for public benefits:

1) _____ I am a United States citizen.

2) _____ I am a legal permanent resident of the United States.

3) _____ I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act with an alien number issues by the Department of Homeland Security or other federal immigration agency.

My alien number issues by the Department of Homeland Security or other federal immigration agency is: _____.

The undersigned applicant also hereby verifies that he or she is 18 years of age or older and has provided at least one secure and verifiable document, as required by O.C.G.A. § 50-36-1 €(1), with this affidavit.

The secure and verifiable document provided with this affidavit can best be classified as:

_____.

In making the above representation under oath, I understand that any person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of violation of O.C.G.A. § 16-10-20, and face criminal penalties as allowed by such criminal statute.

Executed in SAVANNAH (city), Georgia (state).

_____
Signature of applicant

_____
Printed Name of Applicant

SUBSCRIBED AND SWORN
BEFORE ME ON THIS THE
___ DATE OF _____, 20___

Christian Tyson
NOTARY PUBLIC
My Commission Expires:

CHRISTIAN TYSON
NOTARY PUBLIC
Chatham County
State of Georgia
My Comm. Expires August 06, 2027

106 E. Broad Street
P.O. Box 2024
Savannah, Georgia 31402
(912)527-1000

304 Stephenson Avenue
Savannah, Georgia 31401
(912)692-1181

244 Ledford Avenue
Pembroke, Georgia 31321
(912)695-0912

5554 Reynold Street, Ste 420
Savannah, Georgia 31405
(912)555-6990

349 West Bryan Street
Savannah, Georgia 31401
(912)527-2727

907 East 67th Street
Savannah, Georgia 31405
(912)527-1101

1214 N. Columbia Avenue Ste. D
Rincon, Georgia 31326
(912)527-1120

2 Roberts Street
Savannah, Georgia 31408
(912)527-1100

1501 Abercorn Street
Savannah, Georgia 31401
(912)235-7970

800 E. 70th Street
Savannah, Georgia 31408
(912)790-6500

CURTIS V. COOPER PRIMARY HEALTHCARE, INC.

ITEMS NEEDED FOR REGISTRATION

To qualify for a discount on medical and ancillary services at Curtis V. Cooper Primary Health Care, Inc. Patients must provide proof of family income and address. The following may be used.

1. **INCOME VERIFICATION:**
   - A. Wages, including overtime and tips
   - B. W-2 withholding forms
   - C. Current pay stubs
   - D. Previous years Income Tax Returns
   - E. Written verification from employer
   - F. Written verification of income from public assistance agencies (DFCS, churches, United Way, etc.)
   - G. Award letter for: Retirement/ Pension Income/ Social Security/ SSI benefits
   - H. Worker's Compensation
   - I. Unemployment Benefits (letter must include amount)
   - J. Veteran's Benefits
   - K. Child Support
   - L. Alimony
   - M. Notarized letter of support (If living with someone letter is to state that head of household is providing support for you while unemployed)
     (For individuals who support themselves from their saving and/or checking account must include a copy of their last bank statement (s) with the notarized letter of support)

2. **VERIFICATION OF HOUSEHOLD SIZE:**
   - A. Social Security cards for family members your income supports
   - B. Prior year's tax returns
   - C. Passports
   - D. Birth Certificates

3. **CURRENT ADDRESS VERIFICATION:**
   - A. Driver's license or ID card/ with address that matches
   - B. Copy of utility bill (electric, gas, water)
   - C. Lease (copy of receipt)

4. **INSURANCE/MEDICAL/MEDICARE VERIFICATION**

   If a patient has insurance coverage he/she needs to bring the following items to registration upon every visit.
   - A. Insurance Card, Medicaid, Medicare, or Private.
   - B. Worker's Compensation (Name of employer and contact person with telephone number for insurance verification)

I understand if I do not provider this information on my next visit and or within 30 days to the Health Center. I will be placed on 100% without further notice. I also understand that I will be financially responsible for all charges incurred at the time of my visit.

Signature _____ Date _____ Witness _____ Date _____

Account #_____

Authorization to Release Medical Records

Name of Patient _____ Date of Birth _____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

PATIENT INFORMATION NEEDED FOR

- Continuing Medical Care

INFORMATION TO BE RELEASED OR ACCESSED

History and Physical ☑ Consultation Report ☐ Labs/Path Records ☐

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):

TO:

Curtis V Cooper Primary Health Care Inc.	**(912) 665-6653**
Community Care Partnership Name	Phone Number
106 E Broad Street, Savannah, GA 31401	**(912) 335-3805**
Address	Health Center Fax

FROM:

Patient Provider Name	Phone Number
Address	Provider Fax

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire one (1) year from the date of my signature, unless I revoke the authorization prior to that time.

Date _____ Signature _____

Patient or Legally Authorized Representative

_____

Printed Name of Patient or Legally Authorized Representative

_____

Relationship to Patient