MERCY
HEALTH CENTER

NEW PATIENT PACKET

Our mission is to demonstrate and share the love of Jesus through quality, whole-person healthcare to our underserved neighbors.

MORE INFO

P: 706.425.9445
F: 706.425.0820
mercyhealthcenter.net
700 Oglethorpe Ave C7
Athens GA 30606

MERCY HEALTH CENTER

Required documentation – You must update Annually

Proof of Address

Applicants must reside within one of the 13 counties we serve. Acceptable documents include one of the following:

- A piece of mail showing the applicant's name and current address
- A letter from a facility (if the applicant is currently residing there) confirming that the individual is living on-site
- For applicants who are unhoused and not residing in any dwelling, a residency form may be completed; we can assist with notarization if needed

Proof of Income

Applicants must meet our income eligibility guidelines. Acceptable documentation includes one of the following:

- Three months of recent pay stubs
- Three months of bank statements
- A wage statement from the Department of Labor

If the wage statement shows $0 for the previous 3 months, we require either a letter of support from the individual(s) providing financial assistance or another valid form of income verification. If the applicant has no income and receives no assistance from family, friends, government agencies, churches, or other sources, they may complete a No Income Statement, and we can assist with notarizing the form if needed.

Photo Identification

One of the following forms of ID is required:

- Driver's license
- Passport
- Prison discharge slip or inmate identification card

New Patient Paperwork

All new patient forms are available at the front desk of our office.
Please note that we **cannot** accept a packet until **all** required documents have been completed and submitted. Once we receive the full packet, we will process the request and contact the applicant within 24 hours (excluding weekends) to set up their new patient appointment. Appointments are not available before all paperwork is complete or on the same day the packet is completed.

For Dental (only) Applicants

If you are applying only for the dental department, you will also be required to provide a "Visit Summary" from the previous 12 months from a Primary Care Provider. Hospital visit summaries will not be accepted. These may be emailed, faxed, mailed or delivered in person and are considered part of your required paperwork, due before appointments can be made.

Thank You

MERCY HEALTH CENTER

Are you currently insured? (Dental/Viion/Medical)	
What County do you live in?	
Are you under the care of a primary care provider?	
Are you currently taking any prescription medications?	
What is the number of people in your household?	
Are you interested in DENTAL, MEDICAL, or BEHAVIORAL HEALTH services?	

Household and Household income calculation sheet

1. **Do you file taxes?**

YES - Number of dependents _____

Spouse _____

Add 1 for yourself

1a TOTAL: _____

Please fill out the Unearned and Earned income chart below

Ignore this **NO** section

NO - Are you claimed on someone else's taxes?

a. YES - Who is claiming you as a dependent on their taxes?

_____

1b. Including yourself, how many people are included in THAT tax return?

_____

Please fill out the Unearned and Earned income chart below

Ignore this **NO** section

1c. NO - How many people live in your home (including yourself)? _____

If your answer was >1 (more than 1) please answer the following questions AND fill out the unearned and earned income chart.

1. How many of the people in your home receive income of any kind? (See chart below for what is considered income) _____
2. What kind of income do those additional people receive? And the amount they receive monthly (use provided lines below for this).

- _____$_____
- _____$_____
- _____$_____
- _____$_____
- _____$_____

1d TOTAL :_____

Unearned and Earned income that is included in your income ($ Monthly)

- Alimony: $_____
- Child Support $_____
- Contributions from other people (Friends/ Family) $_____
- Social Security (Disability/ Retirement/Survivor's Benefits) $_____
- Unemployment Benefits/ Compensation/ Insurance $_____
- Worker's Compensation $_____
- Pay Checks from a job $_____
- Cash/ Checks/ Venmo/ Cashapp/ Zell/ PayPal $_____
- Recovery stipend/ Foster Care stipend $_____
- VA benefits: $_____
- Caregiver Compensation: $_____

Unearned and Earned income TOTAL: $_____

Number of people in household: (Add up everything from **1a** , **1b** , **OR 1c**

_____

Average monthly household income from all sources (Add **1d** total **AND** Unearned and Earned income chart total) _____

Consent for Evaluation and Treatment

Mercy Health Center (MHC) is dedicated to providing primary care, certain specialty services, dental health services, limited behavioral health and wellness services. We believe people receive the best care when health care providers work together. Because physical and emotional problems often go together, MHC patients may be referred to other health care specialties within the MHC treatment team, and these team members will communicate regarding patient care, share documentation, and collaborate appropriately to ensure patients receive the best care we are capable of providing.

Initial each section that you understand and to which you agree and sign at the bottom.

Consent to Care

_____ I voluntarily consent to treatment at MHC. I authorize all healthcare providers, including but not limited to, physicians, nurse practitioners, dentists, counselors, and their assistants, employed by or volunteering at MHC to use such diagnostic and treatment procedures they deem necessary for proper management and treatment.

_____ I understand that dental students, medical students, nurse practitioner students, physician assistant students, and counseling students are not licensed providers and may help provide care only under the supervision of and direction of a licensed healthcare provider.

_____ I understand that in treating patients, studies including x-rays, EKGs, or psychological tests may be needed. As healthcare is not an exact science, no guarantees are made concerning the course or effect of the treatment. There are risks involved with taking medications. Any questions about the benefits, risks, available options, and medications should be directed to MHC staff. I accept the risks of medication and other treatment.

CONSENT FOR EVALUATION AND TREATMENT

Confidentiality

_____ I understand that my health information is strictly confidential and may be shared between MHC providers as required or permitted by law, as necessary for evaluation and treatment. Unless otherwise required or permitted by law, identifying patient information will NOT be given to anyone outside MHC, including family and friends, unless the patient (or legal guardian) gives written consent.

_____ I understand that MHC may use or disclose de-identified health information for research purposes. I understand the extent to which this information could be shared is outlined in the Notice of Privacy Practices.

_____ I understand that MHC is dedicated to maintaining patient privacy rights through privacy practices described in MHC's Notice of Privacy Practices. I understand that I can obtain a written copy of this pamphlet at any time from MHC's front office staff.

_____ I received a copy of MHC's Notice of Privacy Practices.

Emergency Procedures

_____ I understand that if I have an emergency, I need to contact either a hospital emergency room or dial 911, depending on the situation.

Agreement to Fees

_____ I understand that I am legally responsible for all charges in connection with the healthcare provided by MHC. I understand that the services provided at MHC's facility are free of charge, but that labs, tests, procedures and appointments carried out by partnering agencies may result in fees and that I am responsible for any amount that is incurred.

_____ I understand that this authorization will continue forever and remain on file and that it, or a copy of it, will be used for future claims, unless I revoke this consent by written notice to: Mercy Health Center, 700 Oglethorpe Ave, Suite C7, Athens, Georgia, 30606.

CONSENT FOR EVALUATION AND TREATMENT

By signing this form, I agree that I have read or had this form read and/or explained to me, that I understand it, and that any questions I asked have been answered. I understand that I agree to be truthful in proving information.

With my signature, I consent to the above and to evaluation and treatment for myself for dental, medical, behavioral health and wellness services, including any studies or procedures the MHC professional staff decide are necessary or appropriate. If signing as a guardian, I hereby represent and warrant that I am legally empowered and entitled to make such decisions.

Patient's Signature: _____ Date: _____/_____/_____

Type or print Patient's name _____

Guardian's Signature _____ Date _____/_____/_____

Type or print Guardian's name _____

MERCY HEALTH CENTER

HIPAA Privacy Authorization Form

Patient name: _____ Date of Birth: _____/_____/_____

Social Security #: _____ - _____ - _____

In case of an emergency, I authorize Mercy Health Center to release my entire record of protected health information (PHI) to the following individual(s):

Name: _____ Relationship: _____

Phone #: _____

Name: _____ Relationship: _____

Phone #: _____

In the case of non-emergency situations, I also authorize disclosure of my entire PHI at any time (including, but not limited to, medications, discharge notes, lab results, appointments) to the following individual(s):

Name: _____ Relationship: _____

Phone #: _____

Name: _____ Relationship: _____

Phone #: _____

☐ I DO NOT AUTHORIZE the release of my health information to anyone.

This authorization is valid until nine (9) months after my death, unless I revoke this authorization in writing. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that my treatment or eligibility for service is not dependent on whether I sign this authorization. I understand that information disclosed under this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of Patient: _____ Date: _____/_____/_____

Signature of Witness: _____ Date: _____/_____/_____

MERCY HEALTH CENTER

Consent For Photography, Video/Audio Taping, Distribution and Publication

The undersigned hereby grants permission to Mercy Health Center ("MHC") to record his/her voice and/or image by photograph and/or video or audio recording during this visit and during any and all future visits occurring on or after the date of signature, for distribution and/or publication by MHC.

The undersigned understands and grants permission for any such photographs or video/audio recordings to be used by MHC, including the distribution of copies, with or without charge, to any persons or entities, including the media and social media platforms, as part of MHC's operations. Such use may include, but is not limited to, promotion, publicity, or any other lawful purpose.

The undersigned further understands and grants permission for MHC or its agents to edit any such photographs or video/audio recordings as they deem necessary or appropriate in their sole discretion.

The undersigned hereby releases to MHC all rights of any kind that he/she may have in any such photographs or video/audio recordings. The undersigned understands that no compensation will be provided for the use of any photographs or video/audio recordings.

The undersigned further releases MHC and its trustees, officers, employees, agents, volunteers, and students from any claims or liability arising out of the use of such photographs or video/audio recordings.

By signing below, the undersigned affirms that he/she has read and understands this document and agrees to the terms and conditions set forth above.

Signature: _____ Date: _____/_____/_____

MERCY HEALTH CENTER

Patient Profile

Basic Information

Last Name: _____ First Name: _____
Middle Name: _____ Preferred Name: _____
Address Line 1: _____
Address Line 2: _____ City: _____
State: _____ Zip: _____ County: _____
Mobile Phone: _____ Home Phone: _____
Email: _____
Date of Birth: _____/_____/_____ Gender (Please circle one): Male Female Other
SSN: _____

Emergency Contact

In order for anyone to call on your behalf, you will need to have them listed either as an Emergency Contact or on your HIPAA Release Form. We cannot release information to anyone that is not listed.

Relation: _____
Guardian (Circle one): Yes No HIPAA (Circle One): Yes No
First Name: _____ Last Name: _____
Address 1:

_____
Address 2: _____ City: _____
State: _____ Zip: _____ Phone: _____
Is this person a current Mercy patient? (Circle one): Yes No

Other Information

Marital Status (Circle One): Single - Married - Divorced - Widowed - Partner - Unknown - Separated
Primary Language: _____
Race: _____ Ethnicity (Circle One): Hispanic - Not Hispanic

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Patient Profile

Preferred Pharmacy: _____
(Please include location – Ex: Publix Atlanta Hwy)

Last Primary Care Physician: _____
Previous Specialty Care Physician: _____
Preferred Hospital: _____
Last Dentist: _____
How many times have you been to the ER in the past 12 months? _____

Past Medical History

Please check if you have ever had any of the following conditions:

- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Arrythmia (irregular heart beat)
- ☐ Artificial Heart Valve
- ☐ Blood Clots
- ☐ Cancer type:_____
- ☐ Congestive Heart Failure
- ☐ Diabetes
- ☐ Emphysema / COPD
- ☐ Eye problems type:_____
- ☐ Heart disease
- ☐ Heart Attack/Failure
- ☐ Heart Pacemaker
- ☐ Hepatitis B or C
- ☐ HIV or AIDS
- ☐ High Blood Pressure (hypertension)
- ☐ High Cholesterol (hyperlipidemia)
- ☐ Kidney Disease
- ☐ Seizures
- ☐ Sexually Transmitted Disease
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Other:_____
  _____

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Patient Profile

Family History

Please list medical problems for these family members and about how old they were when diagnosed. Only include biological family members.

Father: _____

Mother: _____

Siblings: _____

Children: _____

Other medical problems that run in your family: _____

Past Surgeries

Please list any surgeries and the approximate date or year.

_____

_____

_____

_____

Dental History

Do you have any current dental problems? If yes, please explain_____

_____

_____

When was your last dental exam? _____

When was your last dental cleaning? _____

When were your last dental x-rays? _____

Do you feel anxious when you go to the dentist (Circle one)? Yes No If yes, please explain_____

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Patient Profile

Mental Health History

Please check if you have ever had any of the following conditions:

☐ Depression ☐ Anxiety ☐ Bipolar ☐ Schizophrenia

Other_____

Do you have a mental health doctor (psychiatrist) (Circle one)? Yes No

Name of psychiatrist: _____

Do you go to counseling (Circle one)? Yes No

Name of counselor: _____

Have you been prescribed medicines for mental health (Circle one)? Yes No

If yes, please include in medication section

Are you taking your medicine (Circle one)? Yes No

If no, please explain: _____

_____

Current Medications

Please list all current medications and doses, if known. Include prescriptions, over-the-counter medicines, vitamins, supplements, birth control pills, inhalers, and mental health medications.

_____

_____

_____

Spiritual History

What is your faith identity?_____

Where do you worship?_____

What role does your faith play in your life?_____

_____

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Patient Profile

Allergies

Please list any medication allergies or reactions

Medication:_____

Type of reaction: _____

Medication: _____

Type of reaction: _____

Medication:_____

Type of reaction: _____

Medication:_____

Type of reaction: _____

Are you allergic to latex (Circle one)? Yes No

Women's Health History: Men please skip to the next section.

Do you have menstrual periods (Circle one)? Yes No

If no, at what age did they stop? _____

Are your periods regular (Circle one)? Yes No

How many times have you been pregnant? _____

How many children do you have living? _____

Do you use any form of birth control (Circle one)? Yes No

If yes, what type(s)? _____

Have you ever had a mammogram (Circle one)? Yes No

When was your last mammogram? _____ Was it normal (Circle one)? Yes No

Have you ever had a PAP smear (Circle one)? Yes No

When was your last PAP? _____

Have you ever had an abnormal PAP (Circle one)? Yes No

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Patient Profile

Health Habits

Do you smoke or use any tobacco products (Circle one)? Yes No Quit
Types of tobacco: Cigarettes - Cigars - Pipe - Chewing tobacco
How much per day? _____ For how many years? _____
Do you drink alcohol (Circle one)? Yes No Quit
How many drinks per day? _____ How many drinks per week? _____
Do you use other drugs?
(marijuana, cocaine, crack, heroin, meth...) (Circle one) Yes No Quit
List drugs you are using now: _____
Have you ever used injection drugs (Circle one)? Yes No
Do you exercise (Circle one)? Yes No
If yes, what type of activity and how often? _____

MERCY HEALTH CENTER

Social Assistance Form

Please let us know how we can help you today

- ☐ Food
- ☐ Clothing
- ☐ Hygiene
- ☐ Prayer

Is there anything you'd like our team to know? _____

_____

_____

_____

_____

_____

_____

Other services we provide or help you find in the community once you are a patient

- Shelter/ Housing guidance
- Homeless Services
- Smoking Cessation
- Pregnancy Services
- Family/ Parenting Classes
- Aging/ Elder Services
- Nutrition Counseling
- Immigration/ Citizenship
- Disability Application
- Disability Support Group
- Coping Skills Group
- Forgiveness Group
- Connections Group
- Grief Group
- Intimate Partner Violence Group
- Financial Assistance
- Hospital Low Income Assistance
- Employment Assistance

MERCY HEALTH CENTER

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.

Your Rights

You have the right to:

- Get a copy of your health and claims records.
- Correct your health and claims records.
- Request confidential communication.
- Ask us to limit the information we share.
- Get a list of those with whom we've shared your information.
- Get a copy of this privacy notice.
- Choose someone to act for you.
- File a complaint if you believe your privacy rights have been violated.

Your Choices

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

- Answer coverage questions from your family and friends.
- Provide disaster relief.

We may use and share your information as we:

- Help manage the health care treatment you receive.
- Run our organization.
- Pay for your health services.
- Help with public health and safety issues.
- Do research.
- Comply with the law.
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director. • Address workers' compensation, law enforcement, and other government requests.
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records

You may request to inspect or obtain a copy of your health and claims records and other health information we maintain. We will provide a copy or summary, usually within 30 days, and may charge a reasonable, cost-based fee.

Request corrections

You may ask us to correct your health and claims records if you believe they are incorrect or incomplete. We may deny your request but will explain the reason in writing within 60 days.

Request confidential communications

You may ask us to contact you in a specific way (such as at a home or office phone) or to send mail to a different address. We will consider all reasonable requests and must comply if you state that you would be in danger otherwise.

Request limits on use or disclosure

You may ask us to limit how we use or share your health information for treatment, payment, or operations. We are not required to agree and may deny the request if it would affect your care.

Request an accounting of disclosures

You may request a list of disclosures of your health information made during the six years prior to your request, including who received the information and why. This list will not include disclosures for treatment, payment, health care operations, or disclosures you authorized.

Obtain a copy of this notice

You may request a paper copy of this notice at any time, even if you have agreed to receive it electronically. We will provide one promptly.

Designate a representative

If you have granted medical power of attorney or have a legal guardian, that person may exercise your rights and make decisions about your health information. We will verify their authority before acting.

File a complaint

You may file a complaint if you believe your privacy rights have been violated by contacting Mercy Health Center, 700 Oglethorpe Ave, Suite C7, Athens, GA 30606, or by phone at 706-425-9445 ext. 212.

You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by mail at 200 Independence Avenue, S.W., Washington, D.C. 20201, by phone at 1-877-696-6775, or online at www.hhs.gov/ocr/privacy/hipaa/complaints/ We will not retaliate against you for filing a complaint.

MERCY HEALTH CENTER

Your Choices

For certain health information, you have choices about what we share. This section explains how we typically use or share your health information.

How we use or share your health information

Treatment

We use and share your health information to help manage the health care treatment you receive and to coordinate care with other professionals treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Your choices

If you have a preference about how we share your information in the situations below, tell us what you want us to do, and we will follow your instructions. You have the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are unable to tell us your preference (for example, if you are unconscious), we may share your information if we believe it is in your best interest. We may also share information to lessen a serious and imminent threat to health or safety.

Uses requiring your written permission

We will not share your information for the following purposes unless you give us written authorization:

- Marketing purposes (we will explain this in advance and ask you to sign a consent form)
- Sale of your information (Mercy does not sell patient information)

Health care operations and other permitted uses

We may use and disclose your health information to:

- Run our organization and contact you when necessary
- Help with product recalls
- Report adverse reactions to medications
- Report suspected abuse, neglect, or domestic violence
- Prevent or reduce a serious threat to anyone's health or safety
- Conduct health research
- Comply with state and federal law, including disclosures to the U.S. Department of Health and Human Services to ensure privacy law compliance
- Respond to organ and tissue donation requests and work with organ procurement organizations
- Share information with a coroner, medical examiner, or funeral director after death
- Address workers' compensation, law enforcement, and other government requests

MERCY HEALTH CENTER

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services Respond to lawsuits and legal actions We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

- We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request and at the time of your annual patient information update.

Keep for your records

MERCY HEALTH CENTER

Code of Conduct

1. Always treat others with respect.

2.Use words that help and encourage and not words that hurt or are offensive to others.

3.Leave the building in the same or better condition than you found it.

4.If you have a complaint, ask to speak with a staff member or clinic manager.

5.Do not use cell phones inside.

6.Arrive on time to your appointments.

7.Be patient and courteous. Please respect the volunteers who are giving their time to provide you with free healthcare.

8.Be polite to those around you.

9.Thank our volunteers for their kind service.

10. Serve others just as you have been served.