Albany Area Primary Health Care, Inc.

204 N. Westover Blvd., Albany, GA 31707-2983
Phone (229) 888-6559, Fax (229) 436-4107

Patient Acknowledgement Form

Authorization, Consent, and Disclosure

Consent for Treatment

I hereby consent to any treatments or diagnostic studies considered necessary by the Physician, Nurse Practitioner, Physician Assistant or other medical personnel of Albany Area Primary Health Care, Inc.

Information Release

I authorize the release of any medical information including information related to psychiatric care drug and alcohol abuse and HIV/AIDS confidential information necessary to process insurance claims or any medical information that is needed for an utilization review or quality assurance activities.

Assignment of Benefits

I assign all medical and/or surgical benefits including major medical benefits to which I am entitled to Albany Area Primary Health Care, Inc.'s provider and/or representative. This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original.

Childproof Container Waiver

I waive Albany Area Primary Health Care, Inc., of any responsibility in dispensing medication to me. I understand that the medication is not in a childproof container. I understand I will be advised of the directions for taking the medication and the potential side effect(s).

External Prescription History

I authorize Albany Area Primary Health Care, Inc. and its affiliated providers to view my external prescription history via the RxHub service.

I understand that the 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.

HIE Consent & Change Form

The Albany Area Primary Health Care (AAPHC) Health Information Exchange (HIE) grants clinicians participating in your care access to your most up to date medical records. This consent is to establish if you would like to participate in the AAPCH HIE. Note: You can change your consent at any time by going to your healthcare provider and requesting a change.

I give consent to allow access to my medical records, when necessary, to participating healthcare professionals through the AAPHC HIE.

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices.

Our practice will make a good faith effort to obtain written acknowledgement of receipt of the Notice of Privacy Practices provided to the individual. If written acknowledgement is not obtained, our practice must document its good faith efforts to obtain such acknowledgement and record the reason why the acknowledgement was not obtained.

Patient Responsibility

We believe that each patient has a responsibility:

1. To cooperate with the staff.
2. To provide accurate and complete health care information.
3. To indicate whether he/she understands the contemplated plan of medicine and nursing management, and the kind of compliance that is expected of him/her.
4. To keep appointments, if at all possible, or to notify the clinic if unable to do so.

Patient Rights

It is the objective of Albany Area Primary Health Care, Inc. and all professional and supportive personnel working in behalf of the patient to uphold rights of all patients. We believe:

1. That the individual dignity of man should be upheld at all times.
2. All patients should be provided supportive and rehabilitative care to their individual needs and environment.
3. An environment should be provided that contributes to the patient's care, safety and sense of well-being.
4. Fair and humane treatment should be provided to all patients under all circumstances, regardless of considerations of race, color, creed, or national origin, or the source of financial payment for care.
5. Each individual patient has certain rights of privacy regarding care and personal circumstances, medical information, and financial information concerning patients should be treated confidentially at all times. The patient has a right to ask questions and receive appropriate information regarding the nature and extent of his/her medical problem, the planned course of treatment, and the prognosis.
6. Each patient will be given the opportunity for informal participation in his/her health care.
7. The patient has the right to refuse treatment to the extent permitted by law, to be informed of the medical consequences of his/her actions, and to request consultation or referral.
8. The patient has the right to efficient and cost-effective care in order to hold his/her health costs to a minimum.

9. When a neonate, child, or adolescent is a patient, his/her family and/or guardian may represent the patient in securing his/her rights as a patient and shall be given the care appropriate to his/her needs.
10. Each patient has the right to present complaints concerning the quality of patient care that he/she has received.
11. Each patient has a right to a copy of his/her medical records.
12. Each patient has a right to formulate advance directives and to appoint a surrogate to make health care decisions on his/her behalf.

The above includes requisite information for services at Albany Area Primary Health Care, Inc. My signature acknowledges my review, understanding, and consent of all items included herein.

Patient/Guardian Signature

Date