Today's Date:

Patient Information- Please Print

Patient Name:____
First Middle Last

Social Security Number: _________________________ Date of Birth: _____/_____/______

Patient Gender: Male _____ Female _____

Current Address: ____

City:________________________________ St: ______ Zip:________________

Email Address: ____
Telephone:
Home: (______) ______-________ Cell: (______) ______-_______

Work: (______) ______-________

Employer: _______________________________
May we contact you at work: Y / N
Occupation:______________________________
Employer Address:
____

____

Primary Care Taker: ____

Legal Guardian: ____DOB__________________________

Best way to reach you regarding appointments/results: ______________________________________

Is it okay to leave a message? Yes ____________ No __________________

Spouse Information (If patient is a child, please complete for parent or guardian)info needed if you are covered under your spouses insurance)

Name: ____
First Middle Last

Social Security Number: _____________________ Date of Birth: _____/_____/______
Telephone
Home: (______) ______-_______ Cell: (______) ______-_______

Address (if different from patient):____

____

Employer: _______________________________ Employer Phone: (______) ______-_______

Employer Address: ____

EMERGENCY CONTACT – Please give additional information for person not listed in patient or spouse section **(example: child, sibling, parent, neighbor, friend)**

Name: _______________________________________ Relationship to patient: __________________

Address: ____

Telephone: (______) ______-_______ Alternate Telephone: (_____)_____-_______

Primary Care and Insurance Information

Primary Care Doctor: ____

City: ____________________________________ Telephone: (_______) _______-________

Providers that you use (*Neuro, Urology, Gyn etc*.) ____

____

Subscriber/Policy Holder Name ____

Subscriber/Policy Holder DOB_________________________ SSN ______________________________

Primary Insurance ID/Policy Number ____

Group Number ______________________________ Subscriber Gender: Male _____ Female _____

Insurance Carrier Name ____

Subscriber/Policy Holder Name ____

Subscriber/Policy Holder DOB_________________________ SSN ______________________________

Secondary Insurance ID/Policy Number _____________________________________

Group Number ______________________________

Insurance Carrier Name ____

Miscellaneous Questions – Please answer all questions

Do you have an Advanced Directive? Yes ______ No ______

If yes, Where is it on file? ____

Would you like information about Advanced Directives? Yes ______ No _______

Reason for today's visit: ____

Participation in Patient Portal: Yes ________ No __________

Preferred means of communication: Portal / Phone / Mail

Race: Asian / Hispanic / African American / Caucasian / Declined to Report

Ethnicity 1. Hispanic/Latino 2. Not Hispanic/Latino 3. Unreported 4. Declined 5. Unknown

Primary Language ____

Tift Regional Physician Services

Abbeville Primary Care – Affinity Clinic – Affinity Pediatrics- Affinity Physicians for Women - Affinity Hospital Medicine Transition Clinic
Allure Plastic and Reconstructive Surgery – Ashburn Primary Care - Arthritis and Osteoporosis – Employee Medical Home
Cook Primary Care-Cook Family Wellness Center- Diabetes Learning Center- Fitzgerald Womens Clinic-Georgia Sports Medicine-Irwin Primary Care – Nashville Primary Care-Ocilla Pediatrics-Ocilla Primary Care -Sylvester Family Practice - Tift Family Medicine and Wound Care Center – Tift Family Medicine - Tift Community Health Center - Tift Regional Anesthesia/Pain Management – PCMH Employee Clinic – South GA Surgical – Tift Regional Vascular

Medical Records Department
2225 Hwy 41 North Tifton, GA 31794
Phone (229) 391-4160 Fax (229) 391-4495

AUTHORIZATION TO RELEASE/OBTAIN PROTECTED HEALTH INFORMATION

Patient Name: ______________________________ Medical Record Number:_______________

Date of Birth: ________________________ Social Security # ____________________________

1. I hereby authorize the use or disclosure of the above named individual's health information as described below TRMC/Tift Regional Physician Services is authorized to make the disclosure of the following information as indicated: (check all that apply)

- ☐ problem list ☐ most recent discharge summary
- ☐ medication list ☐ most recent history and physical
- ☐ physician orders ☐ physician progress notes
- ☐ laboratory results from date _____________ to date _______________
- ☐ x-ray / imaging reports from date _____________ to date _______________
- ☐ x-ray films from date _____________ to date _______________
- ☐ consultation reports from (doctor's name) __________________________
- ☐ entire record limited to from date _____________ to date _______________
- ☐ other____

____

2. I understand these records may contain information concerning sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), drug abuse, alcoholism, sickle cell anemia, and behavior or mental health services.
3. This information may be disclosed to and used by the following individual or organization:

   Name: ______________________________Phone No: ___________________________

   Address: ____

4. For the following purpose: (check all that apply)

- ☐ Legal Issue ☐ Insurance Claim ☐ Personal Use
- ☐ Continuing Care ☐ Other (explain): ____

5. I understand that this authorization, except for action already taken, may be revoked by me at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. Unless otherwise revoked, this authorization will expire one (1) year from today's date and must post date any date of service being requested.
6. I understand that TRMC/ Tift Regional Physician Services will not condition treatment, payment, enrollment, or eligibility for benefits concerning my health care on whether I sign or refuse to sign this authorization.
7. I understand that authorizing the disclosure of this health information is voluntary and that disclosure of such information carries with it the potential for unauthorized re-disclosure.

____ ___________________________ ____________________
Signature of Patient or Legal Representative Date Signed Time

__________________________ ________________ ___________________________
Print Name Relationship to Patient Signature of Witness

Tift Regional Health System
P.O. Box 747
Tifton, GA 31794
Telephone: 229-353-7120

AUTHORIZATION FOR PATIENT PORTAL

Patient Name: ____

Date of Birth: ____

1. I hereby authorize the use or disclosure of the above named individual's health information as described below. Tift Regional Health System is authorized to make disclosure of the entire medical record.

2. I understand these records may contain information concerning sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), drug abuse, alcoholism, sickle cell anemia, and behavior or mental health services.
3. This information may be disclosed to and used by the following individual:

   Name: __________________________ Phone No: _______________________

   Address: ____

4. For the following purpose: (check all that apply)

☐ Legal Issue ☐ Insurance Claim ☐ Personal Use
☐ Continuing Care ☐ Other (explain): ___________________________________

5. I understand that this authorization, except for action already taken, may be revoked by me at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. Unless otherwise revoked, this authorization will expire upon my death.
6. I understand that TRHS will not condition treatment, payment, enrollment, or eligibility for benefits concerning my health care on whether I sign or refuse to sign this authorization.
7. I understand that authorizing the disclosure of this health information is voluntary and that disclosure of such information carries with it the potential for unauthorized re-disclosure.

______________________________ __________ ________________________

Signature of Patient or Legal Representative Time Date Signed

_______________________ ________________ ____________________/_____

Print Name Relationship to Patient Signature of Witness / Time

TIFT REGIONAL MEDICAL CENTER

Consent to Medical Treatment and Hospital Admission

In consideration of medical services and treatment which may be provided to Patient by the Hospital Authority of Tift County, Georgia d/b/a **Tift Regional Medical Center** (hereinafter "Hospital") and physicians on the medical staff, emergency room physicians, Tifton Pathological Services, PC., and South Georgia Radiology Associates, LLC (hereinafter "Physician(s)"), Patient does hereby agree and consent as follows:

1. CONSENT AND TREATMENT AUTHORIZATION

Patient (or the undersigned representative acting on behalf of Patient), hereby consents to and authorizes the administration of such tests, examinations, medical or surgical treatments, including those involving anesthetics, which in the opinion of the Physician(s) may be necessary or appropriate. Patient also consents to admission to the Hospital if deemed necessary and appropriate. Patient agrees that Hospital may dispose of any tissue or body parts removed in the course of any surgical or medical procedure that may be performed.

In the event that the Hospital or Physician(s) determine that blood specimens should be provided by Patient in order to protect the health or safety of those with whom Patient may come in contact, Patient does hereby consent to such blood withdrawal and to the testing thereof, as well as to the release of test information where this is deemed appropriate for the safety of others.

2. RELEASE FROM RESPONSIBILITY FOR PERSONAL EFFECTS

Patient understands and agrees that the Hospital is not liable for loss or damage to Patient's personal property (including, but not limited to, hearing aids, dentures, prosthesis, jewelry, or money) unless it is accepted by the Hospital for safekeeping. Patient hereby releases the Hospital from any responsibility relating to the loss or damage of Patient's personal property which is not actually delivered to and accepted by Hospital for safekeeping.

3. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient authorizes the Hospital and the Physician(s) to release any information, including all medical information and records, financial information and other information, including, but not limited to, test results, lab reports, psychological or psychiatric conditions, drug abuse or addiction information, alcoholism information, and information regarding infectious or communicable diseases, including HIV or AIDS testing and infection information for purposes of treatment, payment, and health care operations. Third parties to whom/which Patient's information may be released include, but are not limited to: treating providers, insurance companies, governmental agencies, health plans, and other third party benefit providers.

4. PAYMENT OF INSURANCE BENEFITS AND RIGHT TO APPEAL

Patient constitutes and appoints as Patient's attorney-in-fact, to act in the Patient's name, place and stead: (a) the Hospital Authority of Tift County, Georgia d/b/a Tift Regional Medical Center, and/or (b) Physician(s) to make application with any third-party source which might provide benefits for the payment of Patient's Hospital or Physician(s) bill, or any portions thereof. Patient further authorizes the payment from any third-party source to be made directly to the Hospital to be applied toward the Patient's Hospital bill, or any portion thereof, and/or directly to Physician(s) to be applied toward Patient's Physician(s) bill, or any portion thereof.

Patient hereby authorizes and appoints as Patient's attorney-in-fact the Hospital, Physician(s), and/or any of their agents, representatives, and contractors to appeal the denial of any claim for payment and take such steps as they deem necessary to appeal the denial of any claim, including but not limited to: submitting the appeal, receiving appeal-related information, submitting medical information and corrected claims, communicating with the third party payer or claims reviewer, receiving notice in connection with the appeal, and fully participating in the appeals process until a final determination is reached. Patient understands and agrees that this authorization is intended to give the Hospital, Physician(s) and/or any of their agents, representatives, and contractors full and complete authority to appeal a denial of a claim for payment, including but not limited to any claim for benefits that Patient may have under any government payer program, including Medicare, Medicaid, and TriCare. In the event Hospital or Physician(s) desire to appeal a denied claim, Patient agrees to fully cooperate during the entire appeals process by, among other things, completing and executing any additional documents or appointments necessary to allow Hospital and/or Physician(s) to pursue the appeal.

Patient agrees and understands that notwithstanding any appointment or authorization granted under this Section 4, Hospital shall not be obligated to exercise or pursue any interest, privilege, right, or remedy that may be available to Patient. Patient is responsible for providing all insurance coverage and benefits information at the time of admission.

5. PATIENT CONTACT

Patient understands and agrees that the Hospital and Physician(s), and their affiliates, agents, and business associates, may contact Patient at any telephone number provided to Hospital or Physician(s), including any residential or wireless telephone number. Patient authorizes Hospital and Physician(s), and their agents, affiliates, and business associates, to make calls and/or send emails and/or text messages to Patient through the use of pre-recorded or artificial voice messages and/or automatic telephone dialing systems. Patient specifically authorizes Hospital and Physician(s), as well as their agents, affiliates, and business associates, to make calls to any wireless telephone number and/or other number for which the Patient may be charged.

6. PAYMENT FOR SERVICES

In consideration of the services to be supplied by the Hospital and Physician(s), the Patient agrees that Patient shall be personally obligated to pay all applicable charges associated with the services rendered, including deductibles and co-payments. Patient agrees to pay all fees, charges, and expenses, including reasonable attorneys' fees and court costs, associated with efforts to collect Patient's account. Patient acknowledges that the Hospital may sell or assign Patient's account to a third party.

Patient authorizes the Hospital, and its agents, affiliates and business associates, to obtain consumer reports containing Patient's personal data from credit reporting sources for collection purposes. Patient agrees to provide such additional information as is necessary for Hospital, Physician(s), and their agents, affiliates, and business associates, to obtain consumer reports relating to Patient.

7. AUTHORIZATION FOR RELEASE OF ACCIDENT INFORMATION

Patient authorizes any city, county or agency to release to the Hospital and Physician(s) copies of any and all accident or incident reports and statements concerning any accident or incident in which Patient was injured and required treatment in the Hospital.

8. RELEASE FOR LEAVING WITHOUT TREATMENT OR AGAINST MEDICAL ADVICE

Patient understands and acknowledges that leaving the Hospital without receiving treatment and/or against the advice of a physician or other provider may constitute a serious risk to the Patient's life, health, or safety. In the event Patient leaves the Hospital without treatment or against medical advice, Patient assumes the risks and consequences of such actions and hereby releases the Hospital and Physician(s) from any and all responsibility or liability for any adverse effects which may result from such actions.

9. IMPORTANT NOTICE REGARDING INDEPENDENT CONTRACTORS

PATIENT UNDERSTANDS AND ACKNOWLEDGES THAT SOME OR ALL OF THE HEALTH CARE PROFESSIONALS PERFORMING SERVICES IN THE HOSPITAL ARE INDEPENDENT CONTRACTORS AND ARE NOT HOSPITAL AGENTS OR EMPLOYEES. INDEPENDENT CONTRACTORS ARE RESPONSIBLE FOR THEIR OWN ACTIONS AND THE HOSPITAL SHALL NOT BE LIABLE FOR THE ACTS OR OMISSIONS OF ANY SUCH INDEPENDENT CONTRACTORS.

10. RISKS OF TREATMENT

Patient is aware that the practice of medicine is not an exact science and acknowledges that no guaranties have been made to Patient concerning the results of examinations, tests, or medical and surgical treatment or care in the Hospital. Patient acknowledges that certain risks may be associated with the patient's care and treatment, and that these include, but are not limited to: infection, blood clots, hemorrhage, nerve damage, paralysis, blood loss, loss of limb, radiation exposure, scarring, disfigurement, perforation, puncture, allergic reactions, and even death.

TIFT REGIONAL MEDICAL CENTER

Consent to Medical Treatment and Hospital Admission

Patient is aware that the following may be part of Patient's care and treatment at the Hospital:

(1) **Needle Sticks,** such as shots, injections, intravenous lines, intravenous injections, and pricks to draw blood. Material risks associated with needle sticks, include, but are not limited to, nerve damages, infections, infiltration (i.e. the leaking of fluid into surrounding tissue), disfiguring, scarring, loss of limb functions, paralysis and partial paralysis, and death.

(2) **Administration of Medication,** which may be done orally, rectally, topically, or through IV, eye, ear, or nose. Material risks associated with the use and administration of medication include, but are not limited to, allergic reaction, brain damage, or death.

(3) **Physical Test, Assessment, and Treatments**, such as vital signs, internal body examinations, wound cleansing, wound dressing, range of motion checks and other similar procedures. Material risks associated with these types of procedures include, but are not limited to, allergic reactions, infection, severe loss of blood, muscular-skeletal or internal injuries, nerve damage, loss of limb function, paralysis or partial paralysis, scarring, and disfiguring.

(4) **Drawing Blood, Bodily Fluids, or Tissue Samples**, such as that done for laboratory testing and analysis. The material risks associated with these types of procedures include, but are not limited to, paralysis, partial paralysis, nerve damage, infection, bleeding and loss of limb function.

(5) **Insertion of Internal Tubes**, such as bladder catheterization, nasogastric tubes, rectal tubes, drainage tubes, and enemas. The material risks associated with these types of procedures include internal injuries, bleeding, infection, allergic reaction, loss of bladder control and difficulty urinating.

(6) **Radiological Studies**, such as X-rays, CT scans, and MRI scans. Material risks associated with these types of procedures include, but are not limited to, radiation exposure.

11. STUDENT PARTICIATION AND OBSERVATION

Patient understands and agrees that the Hospital may permit medical, nursing, and other students in health care related fields to participate in and observe care and treatment provided to its patients and that doing so is necessary for teaching purposes. Patient authorizes supervised students to observe and participate in any care or procedure deemed a part of the education process.

12. RECEIPT OF PRIVACY PRACTICES AND RIGHTS AND RESPONSIBILITIES

Patient acknowledges and agrees that Patient has received a copy of the Tift Regional Health System Notice of Patient Rights and Responsibilities and Notice of Privacy Practices.

13. MEDICARE BENEFICIARIES

Patient agrees and acknowledges that if Patient is a Medicare beneficiary admitted for inpatient services, Patient has received the "Important Message from Medicare" regarding Patient's rights as a hospital inpatient.

14. PHYSICIAN'S ASSISTANTS AND MID-LEVEL PROVIDERS.

Patient agrees and acknowledges that certain physician's assistants, nurse practitioners, and other mid-level providers are authorized to provide care, treatment, and services at the Hospital.

TIFT REGIONAL MEDICAL CENTER

Consent to Medical Treatment and Hospital Admission

15. PATIENT UNDERSTANDING OF CONSENT

Patient hereby certifies by the execution of this document that he/she has read this Consent to Medical Treatment and Hospital Admission and understands its contents. Patient further certifies that he/she is legally authorized to execute this Consent to Medical Treatment and Hospital Admission.

____

PRINTED NAME OF PATIENT ______________________ **SIGNATURE PATIENT/REPRESENTATIVE** ______________________

REPRESENTATIVE RELATIONSHIP TO PATIENT (if applicable) ______________________

DATE __________ **TIME** __________

☐ Patient is unable to sign written consent for initial treatment but gives verbal consent

☐ Patient is unable to sign or give verbal consent.

WITNESS ______________________ **DATE** __________ **TIME** __________