Logo, company name

Description automatically generated

Phone Number: 662-347-7714

Fax Number: 662-771-1835

402 E. Third Street 404 E. Third Street 200 Milam Street

Leland, MS 38756 Leland, MS 38756 Leland, MS 38756

662-686-5020 662-686-5017 662-686-5013

**MEDICAL INFORMATION**

**LAST NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FIRST NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DOB: \_\_\_\_\_/\_\_\_\_/\_\_\_\_\_ SS#: \_\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_ RACE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GENDER: \_\_\_\_\_\_\_\_\_**

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HOME PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PARENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK PHONE #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRIMARY CARE PROVIDER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PREFERRED PHARMACY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMERGENCY CONTACT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RELATIONSHIP TO STUDENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**GUARANTOR INFORMATION**

**LAST NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FIRST NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY: \_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_ PHONE #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INSURANCE INFORMATION**

**PRIMARY INSURANCE NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ POLICY ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRIMARY POLICY HOLDER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**CONSENT TO TREAT**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give **COX HEALTHCARE CLINIC** consent, permission, understanding, acknowledgement and/or agreement to the initialed items.

Initial

Here **AUTHORIZATION FOR DIAGNOSIS & TREATMENT**

\_\_\_\_\_ to assessment & emergency treatment by **COX HEALTHCARE CLINIC.**

\_\_\_\_\_ to medical examination, treatment, & procedures, which may be performed during the office visits, including, but not limited to, a comprehensive history & physical examination, health screenings, health education & prevention programs, prescriptions, referrals, referral follow-ups, labs, injections, & immunizations as may be advisable or necessary by the nurse practitioner of **COX HEALTHCARE CLINIC.** I understand that no guarantees have been made because of examination and treatment in the clinic. This authorization remains valid unless otherwise directed in writing.

**ASSIGNMENTS OF BENEFITS**

\_\_\_\_\_ to **COX HEALTHCARE CLINIC** to release any medical information to my insurance carrier that is needed to receive payment for services rendered to me or other person listed on patient registration form.

**NOTICE OF PRIVACY PRACTICES**

\_\_\_\_\_ that I have reviewed **COX HEALTHCARE CLINIC** *Notice of Privacy Practices,* which describes how medical information about me may be used and disclosed and how I can get access to this information. A copy was provided to me in application packet and I may obtain a copy of the *Notice of Privacy Practices* upon request.

**PATIENT’S BILL OF RIGHTS & RESPONSIBILITIES**

\_\_\_\_\_ that I have reviewed & agreed with **COX HEALTHCARE CLINIC** Patient Bill of Rights & Responsibilities.   
I have received a copy in the application packet and may receive a copy upon request.

**FINANCIAL AGREEMENT**

Your care at **COX HEALTHCARE CLINIC** is a partnership between you and the staff of **COX HEALTHCARE CLINIC**. We rely on the fees paid by your insurance company to keep the clinic operating. **COX HEALTHCARE CLINIC** is not responsible for any charges by hospital, other physicians, radiology, or specialty labs. **COX HEALTHCARE CLINIC** will ensure acute, chronic and preventive services are available to all patients/students with or without insurance. **ALL** patients/students who desire to have a Sports Physical completed by **COX HEALTHCARE CLINIC** will be responsible for a fee of $25 (**no matter the coverage**).

**PATIENTS WITH NO INSURANCE**

\_\_\_\_\_ I understand that my child does not have insurance at this time and **COX HEALTHCARE CLINIC** will not deny acute visits.

**PATIENTS WITH INSURANCE**

\_\_\_\_\_ that **COX HEALTHCARE CLINIC** will bill the most current insurance on file. I agree to provide current and accurate insurance information at each visit and notify **COX HEALTHCARE CLINIC** with any changes in coverage.

**DISCLOSURE OF PERSONAL HEALTH INFORMATION**

**COX HEALTHCARE CLINIC** will not discuss your personal health information with anyone without your authorization, except those allowed under Federal & State law. List the name, relationship & number of anyone you authorize us to discuss your health information.

|  |  |  |
| --- | --- | --- |
| **NAME** | **RELATIONSHIP** | **CONTACT NUMBER** |
|  |  |  |
|  |  |  |
|  |  |  |

**By signing below, I acknowledge that I have read and understand the above consent and accept its term.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient/Parent/Guardian SIGNATURE DATE**

Logo, company name

Description automatically generated

**GENERAL HEALTH INFORMATION**

Do you consider yourself to be in good health?

O Yes O No O Unknown Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any serious illnesses/medical condition?

O Yes O No O Unknown Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any surgeries? If so, list the surgery & date

O Yes O No O Unknown Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to any medication/food?

O Yes O No O Unknown Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any significant family history & who?

O Yes O No O Unknown Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any additional information:

**LIST ANY MEDICATIONS CURRENTLY TAKING**

|  |  |  |
| --- | --- | --- |
| **MEDICATION NAME** | **DOSE**  (mg, mcg, ml, tab, etc) | **WHEN & HOW OFTEN** |
|  |  |  |
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**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABUT YOU MAY BE USED, DISCLOSED & 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 describes 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 the ways we are permitted to use and disclose information that falls within one of the categories. We must obtain your authorization before use and disclosure of any psychotherapy notes, uses and disclosure of PHI for marketing purposes, and disclosure that constitutes 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 COX HEALTHCARE CLINIC may be billed to and payment may be collected from you, an insurance company or a third party. For example, we might 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 COX HEALTHCARE CLINIC or the hospital. For example, we may disclose medical information about you to people outside COX HEALTHCARE CLINIC who may be involved in your medical care, such as family members, clergy or other purses that are part of your care. For Health Care Operations, we may use and disclose medical information about you for healthcare operations.  These uses and disclosures are necessary to run COX HEALTHCARE CLINIC and ensure that all our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other COX HEALTHCARE CLINIC personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts. **WHO WILL FOLLOW THIS NOTICE?** This notice describes COX HEALTHCARE CLINIC policies and procedures and that of any healthcare professional authorized to enter information into your medical record, any member of volunteer group which we allowed to help you, as well as all employees, staff, and other COX HEALTHCARE CLINIC personnel. **POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION.** We create a record of the care and services you receive atCox HEALTHCARE CLINIC. We need this record to provide you with the quality care and to comply with certain legal requirements. This notice applies to all the records of your care generated by COX HEALTHCARE CLINIC whether made by COX HEALTHCARE CLINIC personnel or by your personal provider. The law requires us to: make sure that medical information about you; and to follow the terms of the notice that is currently in effect. 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 workers compensation.

**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 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 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, COX HEALTHCARE CLINIC. 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. 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 of your care, like a family member or friend. 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 COX HEALTHCARE CLINIC; 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; 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. 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. **COMPLAINTS.** If you believe your privacy rights have been violated, you may file a complaint with COX HEALTHCARE CLINIC or with the Secretary of the Department of Health and Human Services.