Med Center Health®

Primary Care

We are pleased to welcome you to our practice! Our goal is to provide the highest quality primary care for all of our patients in a timely and respectful manner. We ask that you observe the following policies:

- Please allow plenty of time to get to the office for your appointment as you may need to complete paperwork. Please bring your driver's license or identification card, insurance card, and all of your prescription and over-the-counter medications with you at each visit.
- Our office will collect co-pays and any owed amounts at the time of each visit.
- Please arrive on time for your visit. If you arrive 15 minutes or more late, you may be asked to reschedule your appointment.
- We strive to notify out patient of their testing results within one week. If you have not heard from our office in that time frame, please contact us.
- **If you cannot attend your appointment, please notify us as soon as possible. We monitor all "no show" appointments and at three (3) "no-shows" a warning letter is sent. At five (5) "no-shows", you may be discharged from our practice. Please allow for 24 hours' notice to properly cancel your scheduled appointment.**

On behalf of our entire staff, we look forward to seeing you! Let's work together to help you live the satisfying life that you deserve. Please call us at (270) 901-0629 should you need to talk with us before your appointment.

Sincerely,

Med Center Health Primary Care Staff

Med Center Health

MyRecord
Patient Health Portal

The **MyRecord** portal allows you to do the following with just a few simple clicks:

- Access health information online, versus in person
- Request appointments for Diagnostic Imaging procedures
- Review your results
- Review your medication summary

View the **MyRecord** portal from anywhere there is internet access

- Access from your smartphone or tablet
- Manage information 24/7, without waiting

To enroll in MyRecord, you will need your email address you provided during patient registration. If you did not provide an email address during registration, you will need to do so by calling Medical Records at 270-745-1271 between the hours of 8:00am and 4:30pm.

If you did provide your email at registration, you should automatically receive an email from MeditechPortal@chc.net

Open the email you receive from us and click on the link provided to access **MyRecord.**

Enter your desired Log On User ID and password, and select a security question then click Log On.

Click Health Record then Health Summary for an over all view of your information

Explore **MyRecord!**

*Please allow up to 36 hours after discharge for your medical information to be available on **MyRecord**. If you have a question or concern about your MyRecord please contact Medical Records at 270-745-1271*

Med Center Health supports the import of data into some personal health record apps. If you would like to use this feature, download your preferred app onto your smart phone and follow the instructions. If you do not see Med Center Health in the list of facilities, please contact us by emailing api@mchealth.net. We will need the name of the app you are trying to use and the preferred way to contact you if we need more information. We will then work with our patient portal vendor to set up the app. Please note that you must be enrolled in Med Center Health's MyRecord patient portal first before attempting to use a personal health record app to download your protected patient health information.

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MEDICAL CENTER PRIMARY CARE
PATIENT INFORMATION

Please Complete in Full, Sign and Date

Last Name: _____ First _____ Middle _____ Sex: _____
Marital Status: _____ Spouse's Name: _____
Social Security Number: _____ Date of Birth: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell/Message/Other Phone: _____
E-Mail Address: _____
Employer: _____ Occupation: _____
Employer's Mailing Address: _____
City: _____ State: _____ Zip: _____ Phone: _____
Employed (please check): ❑ Full Time ❑ Part Time ❑ Student

Ethnic Origin: W B H I Other _____ Patient declines to answer: _____
Are you allergic to any medications? _____ If so, list: _____

_____

Emergency contact *(a person that does **not** live in the same household!)*

Name: _____
Phone: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____

*****Please give the receptionist your current insurance card so a copy can be placed in your file***

Insurance Name: _____ Insured's Name: _____
Insurance Address: _____ Insured's DOB: _____

INSURED SPOUSE OR PARENT INFORMATION

Name: _____ Relationship to patient: _____
Social Security No: _____ Birthdate: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Employer: _____
Employer's Mailing Address: _____
City: _____ State: _____ Zip: _____

Signature: _____ **Date**: _____ Time: _____

Please check one:

- ❑ I **have** executed an advanced directive (Living Will)
- ❑ I **have not** executed an advanced directive (Living Will)
- ❑ I **would** like information on advanced directives

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Consent, Assignment of Benefits & Financial Agreement

Consent to Diagnostic Tests, Medical Treatment and Procedures:
I do voluntarily consent to care involving diagnostic tests, medical treatment and procedures by the physicians/practitioners of Commonwealth Health Corporation, d/b/a Medical Center Primary Care, their assistants and designees, and other employees of Medical Center Primary Care as is necessary or advisable in their judgment. This consent includes testing for communicable diseases, including but not limited to Human Immunodeficiency Virus (HIV), hepatitis or any other blood-borne infectious disease if ordered for a diagnostic purpose or due to occupational exposure of a health care worker. I acknowledge no guarantee has been made to me as to the results of examination and treatment.

Assignment of Benefits and Financial Agreement:
I certify all information given by me is correct and I accept responsibility for the charges for the care provided. I agree to the assignment of all third-party benefits to Medical Center Primary Care and to any physician, practitioner, organization or independent contractor who provided products or services, and agree to pay all charges not covered by third-party payers. If I am covered by an ERISA plan, with this assignment I specifically authorize my providers to receive copies of all notifications and information that I am legally entitled to receive under the terms of my insurance/health plan and to act on my behalf to appeal benefit determinations. I acknowledge any claim for benefits from a third party payer may be filed by Medical Center Primary Care as a courtesy to me. However, I am primarily responsible for monitoring the filing process and making certain the claim is filed in compliance with the provisions specified by the applicable third party payer. The filing of the claim by Medical Center Primary Care in no way releases me from liability for any portion of the bill not paid by a third party payer for any reason. This writing is intended to be the complete and exclusive statement of the terms and conditions regarding my assignment of benefits and supersedes all previous communications, representations or agreements, whether oral or written. Any terms or conditions proposed by me or on my behalf that differ from or are in addition to the terms of this agreement are rejected and shall not become part of this agreement.

Unless other payment arrangements are approved by Medical Center Primary Care, the account balance is due upon demand. Failure to pay for the services may result in the placement of an account with a collection agency or attorney for collection. All amounts due, as shown in the final statement and/or amended final statement, shall bear interest from the due date until paid at a per annum rate of eight percent (8%). In the event there is a judgment, the amount due shall accrue interest at the judgment rate of six percent (6%) until paid in full. Further, I agree to pay all costs of collection including court costs, interest, attorney fees and collection agency fees.

Contact Information:
I agree Medical Center Primary Care, Commonwealth Health Corporation and their agents, attorneys or collection agencies may contact me regarding medical information or information about my account or for the purposes of collection by telephone at any number provided by me including wireless telephone numbers, and via text messaging or e-mail to any e-mail address provided. Methods of contact may include the use of pre-recorded or artificial voice messages and/or automated dialing.

Release of Information:
I authorize the release of all or part of my records, including information stored in Medical Center Primary Care's corporate-wide database, to my physician(s), whose name I provided at the time of registration, and to any physician or practitioner who has or will provide services to me. I authorize the release of statistical information as required by any local, state or federal agency or managed care program. I authorize the release of my HIV test results to health care personnel in the event of an occupational exposure.

I authorize Medical Center Primary Care and any other holder of medical or other information to release information about me (including medical information concerning psychological or psychiatric conditions, alcoholism and/or drug related conditions and HIV or other blood-borne infectious diseases) as required to complete any claim for benefits due to services rendered to me to any person or corporation which is or may be responsible for all or part of the total charge incurred. The persons or corporations to which this information may be released includes, but is not limited to insurance companies, the Social Security Administration, its intermediaries and carriers, state agencies and workers' compensation carriers, as well as the review organization employed by my employer or the employer of the insured member of my family and any corporation engaged by Medical Center Primary Care to make collection of any unpaid charges. I further authorize my employer to release to Medical Center Primary Care or any agency engaged for the purpose of collecting any unpaid charges, verification of my employment status, including the amount of salary or wages and the number of hours worked.

Information Received:

_____ *(initial)* I understand there are benefits and risks associated with taking controlled substances, including the risk of developing drug tolerance or dependence. I am aware of the risks, benefits and alternatives. I consent to treatment with a controlled substance if my doctor deems it appropriate. I understand a complete prescription history may be obtained from my pharmacy.

_____ *(initial)* I acknowledge receipt of the NOTICE OF PRIVACY PRACTICES.

_____ *(initial)* This authorization is valid until revoked in writing.

_____ *(initial)* My medical/financial information may also be released to the following persons.

_____

If you were sent to us by another physician, please list the physician: _____

Print patient name: _____

_____ *Signature* _____ *Date* _____ *Time* _____ *Relationship (if not patient)*

_____ *Witness*

Medical Center Primary Care
CONSENT, ASSIGNMENT OF BENEFITS, & FINANCIAL AGREEMENT
460009 9/20

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Patient Name: _____ Patient DOB: _____

In order to stay within guidelines of HIPAA, please list any person/persons below that you authorize our office to disclose information to regarding your protected health information. We will not disclose any of your personal health information to anyone other than those listed below, this includes your spouse. **(You do not need to list any of your doctors, workers compensation carrier, auto insurance carrier or lawyer's office.)**

Name: _____ **Relationship:** _____

Phone: _____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Name: _____ **Relationship:** _____

Phone: _____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Name: _____ **Relationship:** _____

Phone: _____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Name: _____ **Relationship:** _____

Phone: _____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Do we have permission to leave information from our office on your answering machine/voicemail, when you are unable to answer the phone? YES NO

_____ _____

Patient Signature **Date**

Valid until revoked by patient

Med Center Health

Treatment with Controlled Substances

Patient Name:_____ DOB:_____

The physician/practitioner has discussed with me the option of treating my condition/pain with a controlled substance. By accepting the prescription for the controlled substance(s) that was prescribed to me, I acknowledge I understand there are inherent risks and benefits associated with treating my condition/pain with a controlled substance. These risks include developing drug tolerance and dependence.

It is my responsibility to take the medicine as prescribed and not more frequently than prescribed. I am not to share this medication with anyone else, including family members. The use of controlled substances can depress my senses and impact driving and work safety. It is discouraged during pregnancy, and may harm the unborn child. There is a potential for overdose, and if I suspect I have had an overdose I should call 911 or go to the emergency room as soon as possible.

The medication should be stored in a safe place, out of the reach of children, and should be properly disposed of after expiration. Any requests for refills must be made during weekday hours before the prescription has expired and may require an office visit.

I give permission for my entire prescription history to be obtained from my pharmacy.

_____ _____

Witness Patient Signature or Person Authorized to Consent for Patient

_____ _____ _____

Date Time Relationship to Patient