Greater Meridian Health Clinic, Inc.

Kemper Family Medical Clinic • Shuqualak-Noxubee Health Center • Winston County Family Medical Center • Oktibbeha Family Medical Center • Scooba Family Medical Clinic • West End TJ Harris • Meridian High SBC

A

PATIENT DATA INFORMATION FORM

BOLD fields required

Prefix: ☐ Miss ☐ Mrs ☐ Ms ☐ Mr

Patient First Name: _____

Patient Last Name: _____

Patient Previous Name: _____

Mailing Address: _____

Street Address (If Different from Mailing Address)

Address: _____

City: _____ ST: ____ Zip: _____

Home Phone: _____

Ok to leave message at Home: ☐ Yes ☐ No

Cell Phone: _____

Work Phone: _____ Ext: _____

Email: _____

(Statements will be addressed to responsible party)

Responsible Party Name: _____

Address: _____

City: _____ ST: ____ Zip: _____

Relationship to Patient: _____

Employer Name: _____

Address: _____

City: _____ ST: ____ Zip: _____

Pay Plan: ☐ Self Pay ☐ Insured

Name of Insurance: _____

Address: _____

City: _____ ST: ____ Zip: _____

Phone: _____

Subscriber Name: _____

Relationship to Subscriber: _____

Insurance Number: _____

Group Number: _____

Pharmacy: _____

Location: _____

Date of Birth: _____

Sex: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced

Social Security: _____

Employment Status: ☐ Employed ☐ Unemployed

Veteran: ☐ Yes ☐ No

Student Status: ☐ Part-time ☐ Full-time

Emergency Contact: _____

Address: _____

City: _____ ST: ____ Zip: _____

Phone: _____

Number of Household Members: _____

Race: Choose One...

Characteristic: Choose One...

Residence Type: Choose One...

Ethnicity: Choose One...

Primary Language: Choose One...

Total Household Income: Choose One...

The above information is true to the best of my knowledge. Permission is hereby given for my medical, hospital, or dental treatment including but not limited to any x-rays, examinations, and dental restorations as may be deemed advisable or necessary by the Attending Physicians or Dentist of Greater Meridian Health Clinic, Inc. or by their consulting Physicians or Dentists. I authorize my insurance benefits to be paid directly to the provider of service. I understand that I am financially responsible for any balance. I also authorize Greater Meridian Health Clinic, Inc. or insurance company to release any information required to process my claims. Permission is hereby granted to exchange information with other service agencies.

_____ _____

Witness Date

_____ _____

Patient or Guardian's Signature Date

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B

REDUCED CHARGES APPLICATION

BOLD fields required

HEAD OF HOUSEHOLD

Prefix: ☐ Miss ☐ Mrs ☐ Ms ☐ Mr

First Name: _____

Last Name: _____

Previous Name: _____

Mailing Address: _____

Street Address (If Different from Mailing Address)

Address: _____

City: _____ ST: ____ Zip: _____

Home Phone: _____

Ok to leave message at Home: ☐ Yes ☐ No

Cell Phone: _____

Work Phone: _____ Ext: _____

Email: _____

Account #: _____

Date of Birth: _____

Social Security #: _____ / _____ / _____

LIST ALL THE PEOPLE WHO LIVE WITH YOU:

Name	DoB	Relationship	Insurance	Employer	Earnings before deductions	Other Income Amount/Sources

☐ I certify that the above information is correct to the best of my knowledge. I authorize the release of any medical or other information about me to the GHMC, Inc. or to an insurance carrier as needed for reimbursement for services rendered. I request that any payment for authorized benefits be made directly to GMHC, Inc. on my behalf. The sliding fee scales have been explained to me, and I understand that if I am eligible for Medicaid, Medicare, or Title XX, I will be charged for services according to my ability to pay and that the information I give may include but are not limited to the following: Employer verification, the Social Security Administration, State Employment Services, Welfare Office, Veteran's Administration, and others as necessary. I understand that if I fail to report all income, I will be required to repay all amounts in full.

☐ I hereby certify that I am without any household income.

☐ I further certify to the best of my knowledge and belief that I have correctly answered all questions concerning available income to support myself and my family.

_____ _____

Witness Date

_____ _____

Applicant's Signature Date

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C

PATIENT DATA TRANSFER FORM

BOLD fields required

Prefix: ☐Miss ☐Mrs ☐Ms ☐Mr

Patient First Name: _____

Patient Last Name: _____

Patient Previous Name: _____

Patient Account Number: _____

Date of Birth: _____

Social Security: _____

Race: Choose One...

Address: _____

City: _____ ST: ____ Zip: _____

Home Phone: _____

Ok to leave message at Home: ☐ Yes ☐ No

Cell Phone: _____

Work Phone: _____ Ext: _____

Email: _____

AUTHORIZATION FOR MEDICAL/DENTAL CARE

Permission is hereby granted for any medical or dental treatment including but not limited to x-rays, laboratory procedures, examinations, injections, dental procedures including local or general anesthesia, as may be determined advisable or necessary by the attending provider of the above-named clinic or by their consulting provider. I understand the **Greater Meridian Health Clinic, Inc. does not honor advance directives and efforts will be made to stabilize and transport me to an emergency facility.**

I authorize the Clinic to furnish, from my patient record, requested information or excerpts to any medical service center, third party payers (for billing purposes) and requisite legal, health or social service facility.

I hereby certify that I have read and understand the above authorization.

_____
Witness

_____
Date

_____
Signature of Patient or Responsible Adult if Patient is a Minor or unable to sign.

_____
Relationship of person signing for the Patient

ASSIGNMENT OF BENEFITS - MEDICARE, MEDICAID AND OTHER THIRD PARTIES

Medicaid/Medicare Recipient's Name: _____

Private Insurance Recipient's Name: _____

Other Third-Party Insurance Name: _____

Medicaid/Medicare/Insurance ID Number: _____

I request payment of all authorized insurance benefits be made on my behalf to GMHC, Inc. I authorize any holder, medical or other information about me, to be released to the Division of Medicaid/Medicare or the Fiscal Agent, any information needed to determine these benefits or the benefits payable for related service.

"**This Authorization is Valid for My Lifetime**"

Recipient's Signature: _____ **Date**: _____

GREATER MERIDIAN HEALTH CLINIC, INC. provides medical services to all eligible individuals regardless of race, color, sex, religion, disability or national origin.

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HIPAA ACKNOWLEDGEMENT FORM

By my signature below, I acknowledge that I have received a Notice of Privacy Practices of Protected Health Information from Greater Meridian Health Clinic, Inc.

Patient First Name: _____ **Patient Last Name**: _____

Account Number: _____

Patient (or Guardian) Signature: _____

Date: _____

Witness Signature: _____

Date: _____

PATIENT CONTACT INFORMATION

I authorize Greater Meridian Health Clinic, Inc. to release my records and discuss my medical condition with the following person(s):

Person's Name: _____ **Relationship**: _____

Person's Name: _____ **Relationship**: _____

Person's Name: _____ **Relationship**: _____

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to Greater Meridian Health Clinic, Inc. or completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individual(s), it may become subject to redisclosure by the individual(s).

Patient Signature: _____ Date: _____