SINGING RIVER HEALTH SYSTEM
BIENVILLE CLINIC

Powered by
MEDICAL ANALYSIS

PLEASE COMPLETE ALL PAGES

Fax to: 228-818-0360
Email to: SRHSB@medaclinics.com
WELCOME TO THE MEDICAL ANALYSIS-GHV CLINIC

To provide health care to employee’s spouses and dependents, we need the following information completed. (Legal Dependents Only – Must be able to provide documentation that they are claimed on yearly tax return)

PLEASE PRINT

Employee’s Name: ___________________________ Badge #: ___________________________

Company Employed By: ___________________________ Department: ___________________________ Date of Birth: ___________________________

Social Security #: _______ - _______ - _______ Home #: ___________________________ Work #: ___________________________

Address: ____________________________________________________________ City: ___________________________ State: ___________________________ Zip: ___________________________

Email address: ____________________________________________________________ Primary Physician: __________________________________________________________

Insurance information: _______ Company Insurance _______ Other _______ No Insurance

SPOUSE/DEPENDENTS INFORMATION (Legal Dependents Only (above 2 yrs)—must claim on tax return)

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<th>NAME (First MI Last)</th>
<th>Social Security #</th>
<th>Birth Date</th>
<th>Relation</th>
<th>Phone # (If over 18 yrs)</th>
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Please complete the following information.

Emergency Contact: ___________________________ Phone Number: ___________________________

All information provided to Medical Analysis-GHV is solely for providing health care benefits to spouses and dependents. All information is maintained confidential.

- I understand that the Employee Clinic is not a substitute for a Primary Physician. I am aware that the responsibility of initiating a yearly examination with a Primary Physician is my responsibility and is encouraged by this clinical staff.

Consent form for treatment
As the employee, I give Medical Analysis-GHV permission for any needed treatment for myself and as parent/legal guardian; I give Medical Analysis-GHV consent to treat any minors listed above. Without parental presence: Yes _____ No _____

Signature: ___________________________ Date: ___________________________
PATIENT PRIVACY QUESTIONNAIRE

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment and health care). **Please note, if patient is a minor and parents are divorced or separated, both parents have a legal right to minor child’s health information unless otherwise permitted by a court of law. Documentation will need to be provided in this case.

_________________________________ Phone ______________________

_________________________________ Phone ______________________

2. Please list the family members or other persons, if any, whom we may inform about your medical condition, ONLY IN AN EMERGENCY.

_________________________________ Phone ______________________

_________________________________ Phone ______________________

_________________________________ Phone ______________________

3. Please list the telephone numbers where you want to receive calls about your appointments, lab or x-ray results, or other health care information if other than your home phone:

_________________________________

4. May messages regarding appointment reminders be left on your telephone answering machine, voicemail or at your place of employment?

   YES __________  NO __________

5. May confidential messages regarding medical treatment, x-ray results, or prescriptions be left on your telephone answering machine or voicemail?

   YES __________  NO __________

PATIENT NAME ________________________________________________

SSN: ___________________________________ DOB __________________

PATIENT SIGNATURE ___________________________________________

   (Guardian if under 18 years of age)
Mark (X) below to give Medical Analysis-GHV permission to receive your medical information from your physician/medical institution:

I, ___________________________ give permission to release my medical information to the office of:

(Patient Name)

Medical Analysis-GHV
3009 Bienville Blvd.
Ocean Springs, MS 39564
Phone # 228-818-0310 Fax# 228-818-0360

Mark (X) below to give your physician/medical institution permission to release your medical information to Medical Analysis-GHV:

I, ___________________________ give Medical Analysis-GHV permission to release my medical information to the following:

(Patient Name)

Name: ___________________________ Phone #: ___________________________

(Physician/Medical Institution)

Address: ___________________________ Fax #: ___________________________

Information to be released:

___ Lab Results
___ Progress Notes
___ Prescription History
___ Personal Contact
___ Radiology Reports
___ Other: ___________________________

I understand that this authorization is voluntary. Medical Analysis-GHV will not condition my treatment/health care services on completing and signing this authorization. I understand that if the organization authorized to receive the information is not a health care provider or health plan, that organization may also disclose my health information. Should this occur, I understand that my information may no longer be protected by federal privacy regulations.

I understand that I may revoke this authorization at any time by notifying Medical Analysis-GHV in writing.

I understand that the information outlined in this release will be disclosed according to the instructions of this release within five business days of Medical Analysis-GHV receiving this release authorization.

This authorization will expire on: ___________________________ or six months from authorization date.

_________________________ ___________________________ ___________________________
Patient’s Name (Please Print) Patient’s S.S. N. Patient’s D.O.B.

_________________________
Patient or Legal Representative Signature

_________________________
Date
Acknowledgment of Receipt of Singing River Health System's Joint Notice of Privacy Practices

By signing this document, I acknowledge that I have received a copy of Singing River Health System's Joint Notice of Privacy Practices.

Patient: ____________________________ Date: ____________________________

Medicare-Medicaid Patients Certification: Authorization to Release Information and Payment Request (if applicable) I certify that the information given by me in applying for payment under Title XVII and XIX of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf.

Signature: ____________________________

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CONSENT AND AUTHORIZATION FOR MEDICAL TREATMENT

Patient's Name ___________________ Patient's DOB: ___________________

I hereby give permission for such examination and treatment as the doctor(s) considers necessary or an advisable plan for treatment.

I understand:

1. This is to certify that I/We, the undersigned, authorize and consent to the administration of diagnostic testing, such as Hepatitis B, HIV, x-rays, photographs, or treatment as may be necessary or advisable by Singing River Health System (SRHS) Clinics and my physician. I/We authorize and consent to photographs and/or videos being taken for medical or legal purposes.
2. That the examination and treatment may include injections, x-rays, drawing blood, medicines, or other healing measures.
3. That unexpected situations may arise and I now give permission, in the event I am later unavailable or unable to consent, for the doctor(s) to do what is necessary to save the health, or life, of the above-named patient.
4. That the practice of medicine and surgery is not an exact science. There are no guarantees of success.
5. That I am financially responsible for all charges whether or not they are covered by insurance.
6. That in case of default, I agree to pay all costs of collection and reasonable attorney's fees.
7. That I hereby authorize this healthcare facility to release any and all information necessary to secure payment of benefits and that a photocopy of this agreement will be valid as the original.

WAIVER OF CLAIM FOR LOSS OR DAMAGE TO PERSONAL PROPERTY

I understand:

1. SRHS CLINICS IS NOT RESPONSIBLE FOR THE LOSS OR DAMAGE TO ANY PERSONAL PROPERTY, INCLUDING BUT NOT LIMITED TO, MONEY, JEWELRY, WATCHES, GLASSES, GARMENTS, DENTURES, DOCUMENTS, AND OR OTHER PERSONAL ITEMS OF VALUE.
2. I UNDERSTAND THAT SRHS CLINICS WILL NOT REPLACE ANY PERSONAL PROPERTY LOST OR MISPLACED DURING MY VISIT THAT I DO NOT DEPOSIT WITH THE SRHS OFFICE MANAGER.

My electronic signature conveys that I have read each section of this Consent and Authorization for Medical Treatment. I have had a chance to ask questions related to each section of the Consent and Authorization for Medical Treatment. I was provided an opportunity to ask questions regarding each section of the Consent and Authorization for Medical Treatment by SRHS staff/personnel. The SRHS staff/personnel answered each of my questions fully to my satisfaction.

SIGNATURE OF PATIENT OR PERSON PERMITTED TO SIGN FOR PATIENT:

[Signature]

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