Cooperative Healthcare Services, Inc.
Patient Information and Authorization Form

Date: _____

Patient Information

Last Name:_____First Name: _____ MI.: _____

Gender: Male or Female SSN: _____ Date of Birth: ____/____/_____ Age: _____

Race – Black or African American / American Indian or Alaska Native / Asian / Caucasian / Hispanic /
Pacific Island/Hawaiian / Refused

Mailing Address: _____ City/State:_____ Zip Code:_____

Primary Phone Number: _____Alternate Phone Number: _____

Alternate Address: _____ City/State:_____ Zip Code:_____

Email Address:_____

Marital Status- Single / Married / Divorced / Widowed / Life Partner Primary Language: _____

Employment Status – Full Time / Part Time / Student / Self Employed / Unemployed / Active duty / Disabled /
Medical Leave / Unknown / Retired – If Retired, Date of Retirement: _____

Patient's Employer/ (if student, name of school) _____

Employer Address _____

Employer Phone Number: _____

Who May We Thank for Referring You to Us? _____

Family Physician: _____ Phone: _____

Spouse or Parent/Guardian

Relationship to patient: _____ Name of Spouse or Guardian:_____

Date of Birth _____/_____/_____SSN: _____ Phone number: _____

Address: _____

Employer: _____

Employer Phone #:_____

Employer Address: _____

WITHOUT THE FOLLOWING INFORMATION, WE CAN NOT FILE A CLAIM AND YOU WILL BE RESPONSIBLE FOR THE BILL ON THE DAY OF SERVICE

Primary Insurance Information

Name of Insurance _____

Card Holder Name _____ Relationship of Card Holder to patient: _____

Card Holder social security #_____ Date of birth of Card Holder_____/_____/_____

Policy Number _____ Group Number _____

Employer _____

Secondary Insurance Information

Name of Insurance _____

Card Holder Name _____ Relationship of Card Holder to patient: _____

Card Holder social security # _____ Date of birth of Card Holder_____/_____/_____

Policy Number _____ Group Number _____

Employer _____

HIPAA Contacts

Name of person(s) you wish to receive any test results, medical or billing information on your behalf:

Name: _____ Relationship to you: _____

Date of Birth: _____ Primary Phone #: _____

Name: _____ Relationship to you: _____

Date of Birth: _____ Primary Phone #: _____

☐ Check box if you would like yourself to be your **only** HIPPA contact.

I acknowledge that this HIPAA authorization remains in effect until I give written notification to discontinue.

_____ _____ _____/_____/_____

Print Name (PARENT OR GUARDIAN IF PATIENT IS UNDER 18) Signature Date

Emergency Contact

Emergency contact (Relative or Friend not living with you) _____ Phone: _____

Emergency contact will not have access to your medical information unless you list them as a HIPAA contact above.

Patient Portal

Cooperative Healthcare Services, Inc. and Southeast Georgia Health System have created a patient portal, mySGHShealthconnection, where you can access your medical information online, anytime.

Would you like to sign up for the mySGHShealthconnection Patient Portal? ☐Yes ☐No ☐ Already Signed Up

If yes, we will email you an invitation to the email address provide above to set up your personal, secure account and you can access important health information at your convenience.

Cooperative Healthcare Services, Inc. Authorizations & Payment Policies

We are dedicated to providing the best possible care and service to you and we want you to understand our financial policies.

Payment is due at the time of service unless prior arrangements have been made. We accept cash, personal checks, VISA, and MasterCard.

You will be asked to confirm your demographic and insurance information at the time of each visit. While this may seem unnecessary, it allows us to maintain current records.

Your insurance coverage is a contract between you and your insurance company. As a courtesy, we will file your insurance claim providing you furnish all pertinent information. However, if your insurance company does not pay the practice within a reasonable period, you will be responsible for payment. This includes charges associated with controverted workman's compensation claims. If we later receive a check from your insurer we will refund any overpayment to you.

We participate in many insurance plans to accept an assignment of benefits. We will bill them; however you may be required to pay a co-payment. **If so, we will collect the co-payment at the time of your visit.**

If you have insurance coverage through a plan in which we do not participate, charges for your care are due at the time of the service.

Not all insurance plans cover certain services. In the event your plan determines a service to be "non-covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

It may be necessary to send some specimens to a reference laboratory for testing, as we provide only basic laboratory services. If such services are provided, you will receive a separate bill from the reference laboratory. In addition, you will receive separate bills for services associated with hospital stays, anesthesia, pathology and radiology. All billing questions and inquiries should be directed to the facility from which you have received a bill.

For all services provided in the hospital, we will bill your insurance and you are responsible for any balance due.

AUTHORIZATION AND AGREEMENT FOR TREATMENT

THE UNDERSIGNED HEREBY MAKES THE FOLLOWING ACKNOWLEDGEMENTS AND AGREEMENTS REGARDING THE TREATMENT TO BE PROVIDED THE PATIENT WHOSE NAME APPEARS ON THIS FORM HEREOF:

CONSENT TO TREATMENT: I understand that medical treatment is necessary for the patient and that such medical care, treatment, and procedures will be performed by employees of Cooperative Healthcare Services, Inc. I hereby grant my authorization and consent to such treatment and procedures, and certify that no guarantee or assurance has been made to the results which may be obtained.

AGREEMENT TO PAY SERVICES: For and in consideration of the care and treatment provided to the patient, I promise to pay all co-insurance and non-covered charge amounts for services rendered at the time of service. I also agree that I will be personally liable for legal fees incurred in collection attempts against any debts I accrue with Cooperative Healthcare Services, Inc.

RELEASE OF MEDICAL INFORMATION: I hereby authorize Cooperative Healthcare Services, Inc. to release my medical information in connection with these services for health insurance purposes or to the patient's personal physician or to a referral physician. I authorize by my signature below direct payment of all benefits to Cooperative Healthcare Services, Inc. and authorize submission of insurance forms with this signature on file. I also understand that my records may be shared within Southeast Georgia Health System when necessary for coordination of my care; and that results of laboratory and/or other diagnostic tests may be mailed directly to me.

STUDENT, MANUFACTURING OR COMPANY REPRESENTATIVE OBSERVATION OR ASSISTANCE: I consent that students, including fellows, residents, Physician Assistants students, Medical Students, interns, Physician Assistants, clinical nursing or technical students, and manufacturing or company representatives, may observe or assist in the care which will be undertaken at Cooperative Healthcare Services, Inc.

PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT: I acknowledge that I have been provided with an opportunity to receive the Notice of Privacy Practices for Southeast Georgia Health System/Cooperative Healthcare Services, Inc. In reviewing the Notice, I also acknowledge that I have been provided with an opportunity to ask questions regarding the Notice and its contents.

I HAVE READ THE ABOVE ACKNOWLEDGEMENTS AND AGREEMENTS AND FULLY UNDERSTAND THE SAME.

Patient Signature_____ Print Name_____
(PARENT OR GUARDIAN IF PATIENT IS UNDER 18) (PARENT OR GUARDIAN IF PATIENT IS UNDER 18)

Date: _____

Telephone Treatment Permission Granted By: _____Witness: _____

2nd Witness: _____

COOPERATIVE HEALTHCARE SERVICES, INC.

Cooperative Healthcare Services, Inc.
Statement of Financial Responsibility

Thank you for choosing **Cooperative Healthcare Services, Inc.** for your medical needs. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding to our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian) is ultimately responsible for the payment of treatment and care. **Payment is due at the time of service unless prior financial arrangements have been made. We accept cash, personal checks, VISA and MasterCard.**
- **Copayments are due at check-in before services are rendered.**
- We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of coinsurance, deductibles and all other procedures for treatment not covered by their insurance plan.
- Patients may incur, and are responsible for payment of additional charges, if applicable.
    - These charges may include:
        - Charges for returned checks- $30.00
- Not all insurance plans cover certain services. In the event your plan determines a service to be "non-covered," you will be responsible to the complete charge. Payment is due upon receipt of a statement from our office.
- It may be necessary to send some specimens to a reference laboratory for testing, as we provide only basic laboratory services. If such services are provided, you will receive a separate bill from the reference laboratory. In addition, you will receive separate bills for services associated with hospital stays, anesthesia, pathology, and radiology. All billing questions and inquiries should be directed to the facility from which you have received a bill.

By my signature below, I hereby authorize assignment of financial benefits directly to **Cooperative Healthcare Services, Inc.** and any associated healthcare entities for services rendered on by behalf. I understand that I am responsible for any balance due.

I have read, understand, and agree to provisions of this Patient Financial Responsibility Form:

Patient's Full Name _____ Date of Birth _____

X _____

Signature of Patient or Legal Guardian _____ Date _____

Cooperative Healthcare Services, Inc.
Cancellation/No Show Policy

Our goal is to provide quality medical care in a timely manner. In order to do so, we have implemented an appointment/cancellation policy. If you are unable to keep your appointment, please call at least 24 hours in advance to reschedule.
Appropriate cancellation of an appointment is calling the office and speaking with the front office staff or leaving a message on the General Voicemail box by 10:00 a.m., one (1) working day in advance of the schedule appointment time. If a patient fails to give appropriate notice three times in a 12 month period, they may be subject to dismissal from the practice.

I have read and understand the information and I agree to the terms described:

X _____

Signature of Patient or Legal Guardian Date