



PATIENT REGISTRATION

PHONE: 601-288-8050

FAX: 601-288-4921

Name: _____ Date of Birth: _____ Gender Male Female
Last First MI Maiden

SS#: _____ Home Phone: (____) _____ Work Phone: (____) _____

Is it ok to contact you at your **Home Phone #?** Yes No At your **Work Phone #?** Yes No

Is it ok to leave you a **message on an answering machine** regarding your appointment? Yes No

Mailing address: _____ City: _____ State: _____ Zip Code _____

Residence Address: _____ City: _____ State: _____ Zip Code _____

Marital Status: Married Never married Widowed Divorced Separated Unknown

Living With: Alone Spouse Children Parent or Guardian Relatives Non-Relatives Unknown

Race: American Indian/Eskimo/Aleut Asian Black White **Ethnicity:** Hispanic Origin Non-Hispanic Origin

Emergency Contact: _____ Phone: (____) _____

Address: _____

Relationship to the Patient: _____

EMPLOYMENT OR SCHOOL INFORMATION

Employer/School: _____ Phone: (____) _____

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

Do we provide EAP services for your employer? Yes No If FGH Employee, give ID #: _____

RESPONSIBLE PARTY INFORMATION

Guardian Name: _____ Home/Day Phone: (____) _____

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

Relationship to Patient: _____ SS#: _____ Date of Birth: _____

INSURANCE INFORMATION

Primary Insurance: _____ Secondary Insurance: _____

I.D. Number: _____ I.D. Number: _____

Phone # for Verification: _____ Phone # for Verification: _____

Mailing Address: _____ Mailing Address: _____

City, State, Zip Code: _____ City, State, Zip Code: _____

Group Name: _____ Group Name: _____

Group #: _____ Group #: _____

Name of Policy Holder: _____ Name of Policy Holder: _____

Social Security #: _____ Social Security #: _____

Date of Birth: _____ Date of Birth: _____

PROVIDER INFORMATION

Referral Source:

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Should we keep your referral source up to date on your progress? Yes No Release of Information Signed? Yes No NA

Patient Signature: _____ **Date:** _____

STATEMENT OF RIGHTS & RESPONSIBILITIES

Our Clinic respects the rights of the patient, as an individual with unique health care needs. In providing this care the clinic has the right to expect behavior on the part of the patient, relatives and friends, which is reasonable and responsible.

Patient Rights:

1. A patient or surrogate decision-maker for a patient has the right to:
 - A. impartial access to treatment or accommodations regardless of race, creed, sex, national origin, religion, handicap or source of payment for care;
 - B. be informed of all patient rights at the time of admission and the rules and regulations applicable to his/her conduct as a patient;
 - C. be treated with courtesy, respect, individual dignity and privacy;
 - D. expect all communications and other records pertaining to his/her care including source of payment for treatment to be treated as confidential;
 - E. participate in decisions involving his/her health care including diagnosis, considerations of ethical issues, course of treatment, alternatives, risks and prognosis;
 - F. expect access to the Ethics Committee when conflict evolves in the decision making process;
 - G. know if medical treatment is for experimental research and to consent or refuse to participate in such experimental research;
 - H. know the identity and professional status of individuals providing services and to know which professional is primarily responsible for his/her care;
 - I. expect reasonable safety insofar as the clinic practices and environment are concerned;
 - J. refuse treatment to the extent of the law and must be told of the potential risks involved with such refusal;
 - K. to be informed of any continuing health care requirements following discharge from the clinic;
 - L. a timely notice of termination of his/her eligibility for reimbursement by any third-party payer for the cost of his/her care;
 - M. request and receive an itemized and detailed explanation of the total bill for services rendered in the hospital;
 - N. prompt and reasonable response to questions and requests; and,
 - O. express grievances regarding any violation of his/her rights as stated in Mississippi law to the health care provider which served him/her, and to the appropriate state licensing agency. (Grievances may be expressed to the Pine Grove Patient Advocate at 288-4951 or to the Joint Commission at 630-792-5000)

Patient Responsibilities:

2. A patient or surrogate decision-maker for a patient has the responsibility:
 - A. to provide accurate and complete information about present and past complaints, illnesses, hospitalization, medications and other matters relating to his/her health;
 - B. to report unexpected changes in his/her condition to the responsible practitioner;
 - C. to report whether he/she clearly understands the course of treatment and what is expected of him/her;
 - D. for following the treatment plan recommended by the practitioner primarily responsible for his/her care;
 - E. for his/her actions if he/she refuses treatment or does not follow the practitioner's instructions;
 - F. for assuring financial obligations for health care are fulfilled appropriately and promptly;
 - G. for following Forrest General/Pine Grove rules and regulations, such as control of noise and smoking
 - H. for being respectful of the property of other persons and the clinic;
 - I. for not participating in the use of illegal drugs and/or alcohol;
 - J. for not bringing firearms, explosives or knives within the boundaries of the clinic property;
 - K. for participating reasonably in discharge planning;
 - L. for keeping appointments and if unable to do so, for any reason, notifying our office; and
 - M. to notify your insurance company within 24 hours of admission. (See back of your insurance card for instructions.)

I have reviewed my rights as listed above and have been given the opportunity to ask questions _____

Patient/Guarantor Signature: _____

Date: _____

Name of Patient: _____

Relationship: _____

**South Mississippi Psychiatric Group/
Pine Grove Outpatient Services
No Show/Cancellation Policy**

I have been informed that I should call at least 24 hours in advance if I am unable to keep my scheduled appointment.

I understand that if I do not call at least 24 hours in advance to cancel or reschedule my appointment, I will be considered a “No Show” for that appointment and will be charged a **\$35.00 fee** for the no show. I understand that this fee will not be paid by my insurance company and that I will be expected to pay this fee at my next visit

I understand that if I develop a pattern of no showing for my appointments my healthcare provider in this clinic may choose to terminate our relationship and refer me elsewhere.

I agree to do my very best to come to every scheduled appointment at this clinic. If I am unable to come, I agree to call at least 24 hours in advance of my appointment.

Patient Signature

Date

PATIENT RIGHTS & RESPONSIBILITIES

Forrest General Hospital's highest priority is serving you, our patient. At the same time, you have responsibilities as a patient that we expect you to fulfill to assist us in caring for you.

Your Rights as a Patient:

- ❖ **Service:** In all cases, your medical treatment and accommodations at Forrest General will be provided impartially without regard to race, creed, sex, disability, national origin, or source of payment.
- ❖ **Respect:** As a patient, you are entitled to considerate, respectful and dignified care.
- ❖ **Privacy:** You have the right as a patient to personal and informational privacy, as follows:
 - ◆ To refuse to talk with or see anyone not officially connected with the hospital involved with your care.
 - ◆ To wear appropriate personal clothing and religious, cultural or other symbolic items, which do not interfere with prescribed treatments or procedures.
 - ◆ To be interviewed and examined in surroundings designed to assure reasonable visual and auditory privacy. This includes the right to request that a person of your own sex be present during physical examinations, treatment, or procedures.
 - ◆ To expect that any discussion or consultation involving your care will be conducted discretely, and that individuals not involved in your care will not be present without your permission.
 - ◆ To have your medical records read only by individuals involved in your treatment, or in the monitoring of its quality, and/or by other legally authorized individuals.
 - ◆ To expect all communication and other records pertaining to patient care, or the source of payment for treatment to be treated confidentially, and to expect same not to be revealed to outside sources, except as provided for by law.
- ◆ To request transfer to another room if another patient or visitors are unreasonably disturbing you. You may request to be placed in protective privacy, if necessary to promote your safety.
- ❖ **Safety:** You have the right to receive care in a reasonably safe setting. As a patient, you have the right to be free from abuse or harassment from any member of Forrest General's staff. You also have the right to be free from uninformed search and/or seizure of your personal belongings. If you have any safety concerns of any kind, please let the Department of Public Safety (84510) know immediately.
- ❖ **Consent:** You have the right to be reasonably informed about and to participate in decisions involving your health and plan of care. You should not be subjected to any procedures without your voluntary, competent and informed consent (or that of a legally authorized representative). In addition, you may be informed of research/education projects or programs for which you may volunteer as a patient, but you will not be required to undergo involuntary treatment or be subjected to research or experimental procedures without your written and informed consent. Refusal to participate in these research/education programs will not affect your treatment in our hospital.
- ❖ **Refusal of treatment:** To the extent permitted by law, you may refuse treatment. However, if your refusal of treatment prevents us from providing you appropriate care according to professional medical standards, the hospital may upon reasonable notice discharge you from its care.
- ❖ **Transfer:** You will not be transferred from Forrest General to another facility unless you have received an explanation of the need for transfer and of the alternatives to such a transfer (and whether the transfer is acceptable to the other facility).
- ❖ **Family participation:** You have the right to have a family member or friend notified promptly of your admission to the hospital. To the extent authorized by you or by law, your family and caregivers may participate in your health care decisions.
- ❖ **Freedom from Restraints:** At Forrest General, you will not be restrained physically or chemically except in an emergency to reduce risk of injury, or as directed by physician. If restraints are required, the least restrictive method will be used and you will be assessed, monitored and re-evaluated appropriately.
- ❖ **Knowledge:**
 - ◆ **About the medical staff and hospital employees:** You have the right to know the identity and professional status of all staff participating in your care, and to know who is primarily responsible for your care.
 - ◆ **Medical Information:** You have the right to know the status (to the degree known) of your condition, including diagnosis, recommended treatment, and prognosis for recovery. You may also obtain a copy of your medical records for a reasonable fee, upon your request and proper authorization.
 - ◆ **Hospital charges:** Regardless of the source of payment for your care, you have the right to request and receive an itemized bill for services rendered at Forrest General or its divisions.
- ❖ **Communication:** You have the right to communicate with people outside the hospital and to have access to an interpreter, when necessary. Other assistance with communication is available upon request.
- ❖ **Consultation:** Your primary physician may request consultation of another physician when deemed necessary. Additionally, you may request a consultation with a medical specialist at your expense.
- ❖ **Counseling:** You and your family have the right to consult with a

clinical ethicist and/or pastoral services upon request.

- ❖ **Advance Health Care Directives (Living Wills):** You have the right to prepare and utilize an advance health care directive (often referred to as a durable power of attorney for health care decisions, or a living will) and to request that same be included in your medical record. The purpose of preparing a health care directive in advance is to allow you to designate a decision-maker to make health care decisions on your behalf, should you for any reason become unable to make such decisions for yourself.
- ❖ **Organ Donation:** According to your wishes and in conformity with applicable law, Forrest General will support the procurement and donation of your organs and other tissues.
- ❖ **Parental control:** If you are a parent and/or legal guardian of a minor patient (under 18), you have the authority to exercise patient rights on behalf of the minor patient.
- ❖ **Hospital rules and regulations:** You have the right to be informed of hospital rules and regulations applicable to your conduct.
- ❖ **Patient Grievances:** In order to improve the quality of our services, you may voice any concern or grievance which you might have regarding the quality of care you receive to a Patient Advocate in Quality Management Services (82255). Presentation of a complaint or grievance will not jeopardize your future access to care.
- ❖ **Pain Management:** Effective pain management will be provided to all patients.

Your Responsibilities as a Patient

- ❖ **Providing information:** You have the responsibility of providing accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to your health. You have the further responsibility to report any unexpected changes in your condition and any problems of any other type (including any violations of your rights) to the responsible practitioner.
- ❖ **Questions:** We at Forrest General understand that medical terminology may be difficult to understand. The employees of the hospital and the

medical staff strive to communicate in simple and direct terms and you can assist us by letting us know if you do not understand.

- ❖ **Complying with instructions:** You must follow the treatment plan. This may include following the instructions of various nurses and other hospital employees as they carry out your doctor or practitioner's orders, and as they enforce applicable hospital rules and regulations. In addition, you are responsible for keeping appointments and, when unable to do so for any reason, for notifying your doctor or practitioner or the hospital.
- ❖ **Safety:** You are responsible for your own actions. While we strive to provide you a reasonably safe environment, you must act safely within it. Think before you step. If you have difficulty walking or experience dizziness, you must request assistance before moving through the hospital.
- ❖ **Advance Health Care Directive (Living Wills):** You should advise the Hospital on each admission if you have an advance health care directive (often referred to as a durable power of attorney for health care decisions or a living will) and should provide a copy to the Hospital to be placed in your medical record.
- ❖ **Refusal of treatment:** If you refuse prescribed treatment or do not follow your doctor or practitioner's instructions, you assume full responsibility for the consequences of your actions.
- ❖ **Hospital charges:** You are responsible for assuring that your hospital bills are paid as promptly as possible.
- ❖ **Hospital rules and regulations:** You are responsible for following hospital rules and regulations affecting patient care and conduct.
- ❖ **Respect and consideration:** You and your visitors are responsible for being considerate of the rights of other patients and hospital personnel, as well as for assisting in the control of noise, smoking, and the number of visitors. You and your guests are also responsible for respecting the property of others, and that of the hospital.
- ❖ **Weapons, Drugs and Alcohol:** You and your visitors are to refrain from

bringing onto hospital property weapons of any kind (guns, knives, explosives or other dangerous objects), illegal drugs and/or alcohol.

- ❖ **Smoking:** Forrest General Hospital is a smoke-free environment and smoking is not allowed inside the hospital.
- ❖ **Parental responsibility:** Parents and legal guardians of minor patients (under 18) are expected to assume the responsibility for their minor patients.

ASK QUESTIONS

You are encouraged to ask questions about any of these rights and responsibilities that you do not understand. On the other hand, if you would like to express concerns regarding the quality of care you receive, please call:

Quality Management Services 601-288-2255

Mailing address:
Forrest General Hospital
Quality Management Services
P.O. Box 16389
6051 U.S. Highway 49
Hattiesburg, MS 39401

You will receive a personal response.

The Mississippi Department of Health is also available to assist you with any question, concern, or grievance by calling 601-576-7300.

Mailing address:
Mississippi State Department of Health
570 East Woodrow Wilson
P.O. Box 1700
Jackson, MS 39215-1700
or to
The Joint Commission
630-792-5000

Presentation of a complaint or grievance will not jeopardize your future access to care.





ForrestGeneral HOSPITAL

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

Patient Name: _____
Account Number: _____
Date of Service: _____

This is to acknowledge that I have received a notice of Privacy Practices from Forrest General Hospital.

Signature: _____
(Signature of patient or guardian if patient is a minor)

Date: _____

FGH 260149



FORREST GENERAL HOSPITAL NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Forrest General Hospital is dedicated to protecting your medical information. We are required by law to maintain the privacy of your medical information and to provide you with this notice of our legal duties and privacy practices with respect to your medical information. Forrest General Hospital is required by law to abide by the terms of this notice.

HOW YOUR MEDICAL INFORMATION WILL BE USED AND DISCLOSED:

We will use and disclose your medical information as part of rendering patient care for treatment, payment or health care operations purposes. For example, your medical information may be used by the doctor or nurse treating you, by the business office to process your payment for the services rendered and by administrative personnel reviewing the quality of the care you receive.

Forrest General Hospital participates in an electronic network for exchanging health and patient information among providers. Your health information will be included in this electronic network unless you object.

We may also use and/or disclose your medical information in accordance with federal and state laws for the following purposes:

Appointment Reminders:

- We may contact you to provide appointment reminders.

Treatment Information:

- We may contact you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fund Raising:

- We may contact you to raise funds for the Forrest General Healthcare Foundation.

Disclosure to Department of Health and Human Services:

- We may disclose your medical information when required by the United States Department of Health and Human Services as part of an investigation or determination of our compliance with relevant laws.

Facility Directory:

- Unless you object, and with the exception of behavioral health patients, we will include your name, location in the hospital, your condition described in general terms and your religious affiliation in our directory of individuals. The directory information, except for your religious affiliation, will be released to people who ask for you by name. Your religious affiliation may be given to members of the clergy, even if they do not ask for you by name, unless you object.

Family and Friends:

- Unless you object, we may disclose your medical information to family members, other relatives or close personal friends when the medical information is directly relevant to that person's involvement with your care.

Notification:

- Unless you object, we may use or disclose your medical information to notify a family member, a personal representative or another person responsible for your care, general condition or death.

Disaster Relief:

- We may disclose your medical information to a public or private entity, such as the American Red Cross, for the purpose of coordinating with that entity to assist in disaster relief efforts.

Public Health Activities:

- We may use or disclose your medical information for public health activities, including the reporting of disease, injury, vital events and the conduct of public health surveillance, investigation and/or intervention.

Health Oversight Activities:

- We may disclose your medical information to a health oversight agency for oversight activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions, administrative and/or legal proceedings.

Abuse or Neglect:

- We may disclose your medical information when it concerns abuse, neglect or violence to you in accordance with federal and state law.

Legal Proceedings:

- We may disclose your medical information in the course of certain judicial or administrative proceedings.

Law Enforcement:

- We may disclose your medical information for law enforcement purposes or to law enforcement officials under certain circumstances. These disclosures may include medical information of inmates to individuals of correctional institutions.

Coroners, Medical Examiners and Funeral Directors:

- We may disclose your medical information to a coroner, medical examiner or a funeral director.

Organ Donation:

- If you are an organ donor, we may disclose your medical information to an organ donation and procurement organization.

Research:

- We may use or disclose your medical information for certain research purposes if an Institutional Review Board or a privacy board has altered or waived individual authorization, the review is preparatory to research or the research is only on decedent's information.

Public Safety:

- We may use or disclose your medical information to prevent or lessen a serious threat to the health or safety of another person or to the public.

Specialized Governmental Functions:

- We may disclose medical information of Armed Forces personnel to military authorities under certain circumstances. If medical information is required for lawful intelligence, counterintelligence or other national security activities, or for the provision of protective services to the President of the United States or a foreign head of state, we may disclose it to authorized federal officials.

Workers' Compensation:

- We may disclose your medical information as authorized by laws relating to workers' compensation or similar programs.

Business Associates:

- We may disclose your medical information to a business associate with whom we contract to provide services on our behalf. To protect your medical information, we require our business associates to appropriately safeguard the medical information of our patients.

AUTHORIZATIONS:

We will not use or disclose your medical information for any other purpose without your written authorization except as otherwise permitted or required by law. Once given, you may revoke your authorization in writing at any time except to the extent that Forrest General Hospital has taken an action in reliance on the use or disclosure as indicated in the authorization. To request a Revocation of Authorization form, you may contact: Forrest General Hospital, Health Information Management Department, P.O. Box 16389, Hattiesburg, MS, 39404 or 601-288-2900.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION:

You have the following rights with respect to your medical information:

- You may ask us to restrict certain uses and disclosures of your medical information. We are not required to agree to your request, but if we do, we will honor it.
- You have the right to receive communications from us in a confidential manner.
- Generally, you may inspect and copy your medical information. This right is subject to certain specific exceptions, and you may be charged a reasonable fee for any copies of your medical information.
- You may ask us to amend your medical information. We may deny your request for certain specific reasons. If we deny your request, we will provide you with a written explanation for the denial and information regarding further rights you may have at that point.
- You have the right to receive an accounting of the disclosures of your medical information made by Forrest General Hospital during the last six years (or following April 14, 2003), except for disclosures for treatment, payment or healthcare operations, disclosures which you authorized and certain other specific disclosure types. The right to receive this information is subject to certain exceptions, restrictions and limitations.
- You may request a paper copy of this Notice of Privacy Practices.
- You have the right to complain to us and/or to the Secretary of the United States Department of Health and Human Services if you believe that we have violated your privacy rights. If you choose to file a complaint, you will not be retaliated against in any way. If you believe your privacy rights have been violated or if you would like further information regarding your rights or regarding the uses and disclosures of your medical information, please contact: Forrest General Hospital, Privacy Officer, P.O. Box 16389, Hattiesburg, MS, 39404 or 601-288-2810.

THIS NOTICE IS EFFECTIVE AS OF JULY 1, 2001.

REVISION OF NOTICE OF PRIVACY PRACTICES:

We reserve the right to change the terms of this notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this notice, we will post a revised notice at Forrest General Hospital and will make paper copies of the revised Notice of Privacy Practices available upon request.

Revised June 1, 2008

South Mississippi Psychiatric Group/Pine Grove Outpatient Services

An Extension of Forrest General Hospital

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

South Mississippi Psychiatric Group/Pine Grove Outpatient Services
An Extension of Forrest General Hospital
1 Lincoln Parkway, Suite 202
HATTIESBURG, MS 39402

Section A: Must be completed for all authorizations

Patient Name:
Address:
Telephone:

Date of Birth:
Soc. Sec. #
Med. Rec. #
Account #:

I hereby authorize SMPG/Pine Grove Outpt Services to disclose to the following information.

This information is to be disclosed for the purpose of:

Covering the period (s) of healthcare: From (date) to (date)
(please state who the medical information should be released to, including their address and the purpose of disclosure)

Information to be disclosed: (check all that apply)

- Entire Health Record(s)
History & Physical
Laboratory Tests
ER Record (s)
Billing Information
Discharge Summary
Operative Report
X-ray Reports
Outpatient Record
Incomplete Record

I understand that this will include information relating to: (check if applicable)

- Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV
Psychiatric Care
Treatment for alcohol and/or drug abuse

Other, please specify:

I hereby authorize SMPG/Pine Grove Outpt Services to obtain from the following information.

This information is to be obtained for the purpose of:

Covering the period (s) of healthcare: From (date) to (date)
(please state who the medical information should be released to, including their address and the purpose of disclosure)

Information to be disclosed: (check all that apply)

- Entire Health Record(s)
History & Physical
Laboratory Tests
ER Record (s)
Billing Information
Discharge Summary
Operative Report
X-ray Reports
Outpatient Record
Incomplete Record

I understand that this will include information relating to: (check if applicable)

- Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV
Psychiatric Care
Treatment for alcohol and/or drug abuse

Other, please specify:

Section B: Must be completed for all authorizations.

The patient or the patient's representative must read and initial the following statements:

- 1. I understand that this authorization will expire on (Month/Day/Year)
2. I understand that I may revoke this authorization at any time by notifying Forrest General Hospital in writing, but if I do it won't have any affect on any action Forrest General Hospital took before they received the revocation.
3. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA.

Section C: Must be completed only if Forrest General Hospital has requested the authorization for its own use or disclosure, or for a disclosure from another health care provider or health plan.

1. Forrest General Hospital must complete the following:
Will Forrest General Hospital receive financial or in kind compensation in exchange for using or disclosing the health information described above? Yes No

- 2. The patient or the patient's representative must read and initial the following statements:
a. I understand that my health care and the payment for my healthcare will not be affected if I do not sign this form.
b. I understand that I may see and copy the information described on this form if I ask for it, and that I can get a copy of this form after I sign it.

(form must be completed before signing)

Signature of patient/patient's representative:
Printed name of patient's representative:
Relationship to the patient:
Date:

Witness (Signature needs to be witnessed by someone other than a family member)

This information has been disclosed to you from the records whose confidentiality is protected by Federal Law. Federal Regulations (42CFR, Part 2) prohibits you from making further disclosure of it without the specific consent of the person to whom it pertains or otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal regulations restrict any use of the information to criminally investigate or prosecute any alcohol/drug abuse patient.

SWORN TO AND SUBSCRIBED BEFORE ME, THIS DAY OF

My Commission Expires:

Notary Public