AMM Healthcare

PATIENT INFORMATION

NAME		SS#	BIRTHDATE	LANGUAGE	GENDER

LOCAL ADDRESS	CITY, STATE, ZIP

DAY OR CELL PHONE #	HOME PHONE #	EMAIL ADDRESS

PRIMARY CARE PROVIDER IF NOT JCMC	ETHNICITY/ RACE	CONTACT PREFERENCE (circle one) PHONE EMAIL MAIL

RESPONSIBLE PARTY INFORMATION (PARENT OR GUARDIAN)

NAME		SS#	BIRTHDATE	LANGUAGE	GENDER

LOCAL ADDRESS	CITY, STATE, ZIP

DAY PHONE #	HOME PHONE #	EMAIL ADDRESS

PERSON(S) AUTHORIZED TO BRING PATIENT TO APPOINTMENT	NAME AND TELEPHONE NUMBER OF EMERGENCY CONTACT

HOW DID YOU HEAR ABOUT OUR PRACTICE? Circle one: Billboard Insurance Friend Family Social Media Phone Book Other

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	

POLICY NUMBER	IF TRICARE (circle): PRIME STANDARD RETIRED ACTIVE

NAME OF POLICY HOLDER OR SPONSOR	DOB	SS#	RELATIONSHIP TO PATIENT

SECONDARY INSURANCE

NAME OF INSURANCE COMPANY	

POLICY NUMBER	IF TRICARE (circle): PRIME STANDARD RETIRED ACTIVE

NAME OF POLICY HOLDER OR SPONSOR	DOB	SS#	RELATIONSHIP TO PATIENT

1. PAYMENT AUTHORIZATION: I hereby authorize payment for all services rendered by AMM Healthcare to be made directly to AMM Healthcare from my insurance company or from the proceeds of a personal settlement.

2. TREATMENT AUTHORIZATION: I hereby authorize treatment to be rendered by the doctors and medical staff of AMM Healthcare.

3. RELEASE OF INFORMATION AUTHORIZATION: I hereby authorize the release of any medical information necessary to process insurance claims and any holder of medical information about me/child to release and such information needed to determine these benefits or the benefits payable for related services.

I also acknowledge that I was provided (*last 2 pages of this package*) with the Notice of Privacy Practices of the AMM Healthcare.

Signature of Patient or Representative: _____ Date: _____

AMM Healthcare

NOTICE OF FINANCIAL POLICY

The staff and providers of AMM Healthcare appreciate your choosing us as your provider. A clear understanding of the practice's financial policy is an essential element to any doctor/patient relationship. It is our policy to provide the best care regardless of source of payment.

- We are happy to file your insurance as a courtesy. Medicaid patients are required to show a current Medicaid card each time. Please be prepared to pay your copay, deductible, previous balances, and non-covered services at the time of your visit. Make sure your insurance information, address, phone number, and email are correct at every visit.

- AMM Healthcare accepts Visa, MasterCard, Care Credit, personal checks or cash. AMM Healthcare reserves the right to reschedule visits if you fail to bring appropriate payment.

- If your insurance requires pre-approval or referral for specialist visits, it is your obligation to assure that the visit/s are approved. Failure to obtain pre-approval or referral may increase the amount you have to pay or lead to the rescheduling of your appointment.

- Outstanding balances over 90 days may be turned over to an outside credit agency. AMM Healthcare reserves the right to add a collection fee.

- Self-Pay Patient – AMM Healthcare accepts patients that do not have insurance coverage. Payment for office visit services is expected at the time of service. Patients **will be billed** for all other tests, procedures, medications, injections, etc. at the discounted rate of 25%. The self-pay discount only applies to patients without insurance coverage.

- Appointment Cancellation Policy - Failure to cancel your appointment without 24 hour notice will result in a **$25 NO SHOW FEE, $50.00 for Specialist**. This fee is NOT covered by your insurance. Any patient having three no shows will be considered for release from our practice.

- NSF (returned) checks – AMM Healthcare charges a NSF fee for every returned check written. Multiple returned checks will result in dismissal of the patient.

- The adult accompanying the minor will be the individual responsible for payment of copays, co-insurance, deductibles, non-covered services, and non-participating insurance balances at the time of service. We do not get involved in domestic disputes over balances.

- AMM Healthcare assesses a $10.00 charge, per chart, for medical records printed for and given to an individual. Chart transfers from AMM Healthcare to another provider are free of charge. You are responsible for payment at the time you drop off the forms for completion.

- AMM Healthcare reserves the right to cancel or reschedule your appointment for unpaid balances, patient non-compliance, inappropriate behavior, or mistreatment of our staff.

Our billing office is available to answer questions regarding our financial policy or setting up a payment plan. Specific coverage issues will need to be addressed by your insurance company member services department.

I have read, understand and agree to the above financial policy:

Printed Patient Name: _____ DOB: _____

_____ **Today's Date: _____**

Patient/Parent/Legal Guardian signature

AMM Healthcare

Authorization for Release of Information

Name of Patient _____ Date of Birth _____

AMM Healthcare is authorized to release protected health information about the above named patient in the following manner and to persons listed. Please fill out all information; if have any questions please do not hesitate to ask one of our staff. Thank-you!

Who may Receive Information. Check each person/entity that you approve to receive information.	**What information can be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Appointment reminders ☐ Other_____
☐ Other person(s) (provide name and phone number) _____ _____ _____	☐ Financial ☐ Medical ☐ Appointment Reminders ☐ Other Health Providers
☐ Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: _____
☐ For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
☐ Photo of patient received by patient or legal guardian ☐ Photo taken by staff (Example: pre/post procedure) ☐ Other	☐ May be posted in office ☐ May be posted on website ☐ Other_____

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____ Date _____

Signature of Patient or Personal Representative (Description of Personal Representative's Authority; attach necessary documentation)

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Adult Patients Intake Form:

Name:_____
Date of Birth: _____

1. Employment (circle one): UNEMPLOYED / EMPLOYED / RETIRED If EMPLOYED, Occupation:_____

2. Do you have a Legal Guardian? (circle one): NO / YES
Name/Relationship:_____

3. Do you have someone who can legally make healthcare decisions on your behalf, such as a Healthcare Proxy or

Healthcare Power of Attorney? (circle one): NO / YES Name/Relationship:_____

4. Do you have a Primary Caregiver? (circle one): NO / YES Name/Relationship:_____

5. Do you have any Advance Directives? (DNR, No Tube Feeding, No Blood Products, etc.?) NO / YES

If YES, what type:_____

6. Smoking Status (circle one below): Second Hand Smoke Exposure? YES / NO

NEVER SMOKER / FORMER SMOKER / CURRENT SMOKER Cigarettes per day:____ # of years ____

7. How often do you consume alcohol? (circle one) NEVER / FORMER / OCCASIONAL / WEEKLY / DAILY

8. Do you use any substances? NO / PREVIOUSLY / CURRENT Specify Type:_____

9. Have you ever been diagnosed with a Mental Health issue? YES / NO

10. Is there any family history of: Alcoholism? YES / NO Substance Abuse? YES / NO Mental Health Issues? YES / NO

11. Communication Barriers: NONE / Hearing Impaired / Vision Impaired / Cognitively Impaired

12. Do you have social support systems? (circle any/all) NONE / FAMILY / FRIENDS / CO-WORKERS / RELIGIOUS

13. Are there any environmental risks at home? NO / YES Please specify:_____
(lack of safe housing, etc.)

14. Are there any environmental risks at work? NO / YES Please specify:_____
(chemical / noise exposure, etc.)

15. Have you self-referred to any specialists? NO / YES Please specify:_____

16. Do you take Over-The-Counter medications? NO / YES Please specify:_____

17. Do you take Herbal medications? NO / YES Please specify:_____

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Patient Name: _____ Date of Birth _____

HEALTH HISTORY FORM

Today's Date: _____ Age: _____

Date of last physical exam (and/or pap smear): _____

List any known allergies: _____

Date of last flu shot: _____ Date of last tetanus shot: _____ Date of last pneumonia shot: _____

What is the reason for your visit? _____

Do you have a living will? _____

SYMPTOMS: Check symptoms you currently have or have had in the past year

General
□ Anxiety
□ Bipolar Disorder
□ Chills
□ Depression
□ Dizziness
□ Fainting
□ Fever
□ Forgetfulness
□ Headache
□ Loss of Sleep
□ Loss of Weight
□ Nervousness
□ Numbness
□ Seizure
□ Sweats

Gastrointestinal
□ Appetite Poor
□ Bloating
□ Bowel Changes
□ Constipation
□ Diarrhea
□ Excessive Hunger
□ Excessive Thirst
□ Gas
□ Hemorrhoids
□ Indigestion
□ Nausea
□ Rectal Bleeding
□ Stomach Pain
□ Vomiting
□ Vomiting Blood

Eye, Ear, Nose, Throat
□ Bleeding gums
□ Blurred Vision
□ Crossed Eyes
□ Difficulty Swallowing
□ Double Vision
□ Earache
□ Ear Discharge
□ Hay Fever
□ Hoarseness
□ Loss of Hearing
□ Nosebleeds
□ Persistent Cough
□ Ringing in Ears
□ Sinus Problems
□ Vision – Flashes

Men Only
□ Breast Lump
□ Erection Difficulties
□ Lump in Testicles
□ Penis Discharge
□ Sore on Penis
□ Other

Women Only
□ Abnormal Pap
□ Bleeding between periods
□ Breast Lump
□ Extreme Menstrual Pain
□ Painful Intercourse
□ Vaginal Discharge
□ Other

Muscle/Joint/Bone

Pain, weakness or numbness in:
□ Arms □ Hips
□ Back □ Legs
□ Feet □ Neck
□ Hands □ Shoulders

Cardiovascular
□ Chest Pain
□ High Blood Pressure
□ Irregular Heart Beat
□ Low Blood Pressure
□ Poor Circulation
□ Rapid Heart Beat
□ Swelling of ankles
□ Varicose Veins

Skin
□ Bruise Easily
□ Hives
□ Itching
□ Change in Moles
□ Rash
□ Scars
□ Sore that won't heal

Date of last period: _____

Date of last pap smear: _____
Have you had a mammogram? _____
Are you Pregnant? _____

Genito-Urinary
□ Blood in urine
□ Frequent Urination
□ Lack of bladder control
□ Painful Urination

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(Continue to next page)

Patient Name: _____ Date of Birth _____

CONDITIONS: Check conditions you currently have or have had in the past year

□ AIDS
□ Alcoholism
□ Anemia
□ Anorexia
□ Appendicitis
□ Arthritis
□ Asthma
□ Bleeding Disorders
□ Blood Transfusion
□ Breast Lump
□ Bronchitis
□ Bulimia
□ Cancer, Type _____
□ Cataracts
□ Chemical Dependency
□ Chicken Pox
□ Diabetes
□ Emphysema
□ Epilepsy
□ Glaucoma
□ Goiter
□ Gonorrhea
□ Gout
□ Heart Disease
□ Hepatitis
□ Hernia
□ Herpes
□ High Blood Pressure
□ High Cholesterol
□ HIV Positive
□ Kidney Disease
□ Liver Disease
□ Measles
□ Migraines
□ Miscarriage
□ Mononucleosis
□ Multiple Sclerosis
□ Mumps
□ Pacemaker
□ Pneumonia
□ Polio□ Venereal Disease
□ Positive TB Test
□ Prostate Problem
□ Psychiatric Care
□ Rheumatic Fever
□ Scarlet fever
□ Stroke
□ Suicide Attempt
□ Thyroid Problems
□ Tonsillitis
□ Tuberculosis
□ Typhoid Fever
□ Ulcers
□ Vaginal Discharge

# of Pregnancies: ____ # of Deliveries: ____ # of Miscarriages: ____ # of Abortions ____ Complications: _____

Hospitalizations (Date, Reason, Outcome): _____

_____

Surgeries (Date, Types): _____

_____

Fractures, Serious Injuries: _____

_____

Occupation: _____Check if exposed to □ Heavy Lifting □ Hazardous Substances □ Stress

Check which substances you use, describe the frequency:

□ Tobacco _____ □ Alcohol _____ □ Caffeine _____ □ Drugs _____

Preferred Pharmacy Name: _____ Phone: _____

MEDICATIONS List medications you are currently taking

_____

_____

_____

_____ _____

Patient's Signature Date

AMM Healthcare

Patient Name: _____ Date of Birth _____

FAMILY HISTORY

Relation	Age	State of Health	Age of Death	Cause of Death	Circle if blood relatives had any of the following: Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer, Type:_____	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Stroke	
Sisters					High Blood Pressure	
					Kidney	
					Tuberculosis	
Children					Other	

Other information you feel is important for the doctor to know about you:

_____

_____

_____

_____

_____

_____ _____

Patient Signature Date

Informed Consent & Controlled Medication Use Agreement

Patient Name: _____ Date of Birth:_____

I understand that I or my dependent child has a condition(s) whose treatment may require the use of controlled substances including opioid pain medications, controlled stimulants, or anti-anxiety medications as

defined by the North Carolina Medical Board. After carefully discussing risks, benefits and alternatives with my provider, I wish to be treated for this condition with controlled medications as prescribed below:

Medication/Strength	*Dosage/Quantity*	*Refill Schedule*

The Patient agrees to and accepts the following conditions. Failure to comply with the conditions in this agreement may result in these medications being discontinued and possible termination of the prescriber/patient relationship.

1. New patients requesting prescriptions for controlled substances as continuing care will be required to provide records from their previous provider documenting their treatment history.

2. I will take or allow my dependent child to take the medication only as prescribed by my AMM Healthcare provider(s). I will not change how these medicines are taken without prior specific permission from my prescribing provider. I will not take or give to my dependent child any sedatives, alcohol or other controlled medications without the prior approval of my provider. I will not take or permit my dependent child to take any other medications including those borrowed or accepted from friends or family members or any illicit or street drugs.

3. If other providers prescribe controlled medication(s) for me or my dependent child for other conditions, I will inform them of this agreement before they prescribe for me and I will promptly notify the provider who created this agreement with me of the new medication(s).

4. I will have all prescriptions for controlled medication(s) filled only at the following pharmacy:
   _____

5. In the event that I must use another pharmacy to fill my prescription, I will notify my provider as soon as possible.

6. I authorize my provider and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the North Carolina Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my controlled medicine. I authorize my provider to provide a copy of this agreement to my pharmacy. I agree to wave any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

7. I understand that AMM Healthcare participates in North Carolina Controlled Substances Registry. Patient prescription history will be reviewed and any discrepancies may result in dismissal from the practice.

8. Refills will be given only during office hours with three business-days advance notice. If my controlled medication(s) is/are lost, misplaced or stolen or if I finish them earlier than prescribed, they will not be replaced.

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9. I will meet regularly with my provider or practice providers for scheduled appointments. I understand that my failure to make and keep these appointments may prevent my medication(s) being filled.

10. I understand that my provider or child's provider, may require specialist evaluation of my condition and treatment and I agree to keep appointments when my provider refers me. New patients who are referred to pain management or psychiatry will have three months to establish care with the specialist.

11. Success in treatment is measured by my ability to function. Evidence of improved functioning is a requirement for continued treatment. I understand that my provider may change or discontinue this medication if there is no longer evidence that I am receiving a reasonable therapeutic benefit from the medication or that I am no longer a good candidate to continue the medication(s).

12. I agree to taper my dose of the controlled medication(s) to determine their effectiveness on request of my provider.

13. If I am unable to tolerate any controlled medication(s), or if I wish to request changes in dosage or medication(s), I agree to properly dispose of my medications per regulatory guidelines.

14. I understand that it is my responsibility to keep others and myself from harm, including the safety of my driving. If there is any question of impairment in my ability to safely perform any activity, I agree not to attempt to perform such activity until I have discussed this with my provider.

15. I agree to store my medications in a secure location.

16. I further accept full responsibility for any sickness, injury or untoward event which may happen to anyone else as a result of my taking any of the medications prescribed by this provider.

17. I agree to a blood or urine test for drug analysis at any time it is requested by the provider or child's provider. Random drug and alcohol screens are for my protection. I understand that my use of alcohol or recreational drugs or failure to comply with the requested blood or urine testing may result in denial of further prescription for controlled medication(s).

18. I understand that I am responsible for obtaining the hard copy of my prescription unless an exception is authorized by the prescriber. If another Individual is authorized to pick up a prescription on my behalf, that individual must be listed in my HIPAA documentation and provide a copy of their photo ID to AMM Healthcare front desk staff.

19. I agree that I will not give, sell or in any way distribute prescribed medications to others.

20. I agree I will not in any way attempt to forge or alter a prescription.

21. I agree to bring my medication(s) to the office to be counted if requested.

22. I agree that I will not verbally abuse clinic staff.

23. If I deviate from the above agreement, I understand that the controlled medication(s) may be tapered and not re-prescribed and may result in my or my child's dismissal as a patient from AMM Healthcare.

24. This controlled medication agreement replaces and invalidates all previous controlled medication agreements made for this chronic condition. I understand that by signing this agreement, I must abide by the rules above which are for my or my child's protection and safety, and that failure to abide by this agreement will result in the termination of medication prescriptions and possibly the termination of all services from my provider and his or her practice.

25. I understand that AMM Healthcare has an on-call provider and an Urgent Care to address urgent concerns about prescribed medications that may arise during non-clinic hours. After-hours access information can also be obtained at www.thejacksonvilleclinic.com.

Additional Conditions and Information for Patients prescribed Opioid (Narcotic) Pain Medications:

a. These medications are being prescribed only for the purpose of treating pain. Along with medications, other medical care may be prescribed to improve the ability to do daily activities. This may include exercise, use of non-opioid analgesics, physical therapy, psychological evaluation/ counseling, weight management, classes on managing pain, integrative therapies such as acupuncture and Healing Touch, or other beneficial therapies or treatment.

b. I understand that a reduction in the intensity of my pain AND improvement in my daily life functions are the goals my treatment plan. Should it become evident that these goals are not being met with the use of pain medications, I understand the medications may be weaned and/or discontinued.

c. I understand that the long-term effects of opioid therapy have yet to scientifically be determined and treatment may change throughout my time as a patient. I understand, accept and agree that there may be unknown risks associated with the long-term use of opioids and my doctor will advise me as knowledge and training advance and will make appropriate treatment changes.

d. I understand that all medications have potential side effects. For pain medications, these include but are not limited to: addiction, physical dependence, pseudo non-addiction, chemical dependence, constipation which may be severe enough to require medical treatment, difficulty with urination, drowsiness, cognitive impairment, nausea, itching, depressed respiration, reduced sexual function and adverse effects or injury to the organs. A distinct clinical syndrome, "hyperalgesia syndrome", has been described in the literature and can actually result in increased pain from continual and escalated does of opioid medication.

e. I understand if I take more medication than prescribed or combine opioids with other sedating medication or alcohol it could result in coma, organ damage, or even death. These interactions are especially dangerous if I have lung disease such as COPD or sleep apnea.

f. Women of child bearing age: I understand if I am planning to become pregnant, if I become pregnant or if I think I may be pregnant, I will notify my prescriber immediately. I further accept that any medication may cause harm to my embryo/fetus/baby and hold the prescriber and all staff harmless for injuries to the embryo/fetus/baby.

g. I have read the above and have had all my questions answered. I know that pain can be managed with many types of treatments. If I am receiving pain medications for a trial period, for an acute or subacute condition or for a specific timeframe such as a work-related injury then this agreement applies to the timeframe that this provider prescribes pain medication.

h. Opioid medication is only one part of my pain management plan of care. There is limited scientific data to suggest that using opioids over 4-5 months will lower my pain and or improve my daily function. There is some scientific information that suggests using opioids can increase my pain, make me feel less well, and increase my risk of unintentional death directly related to the opioid medication. I know that if my provider feels my risk from opioids is greater than my benefit, I may have my opioids compassionately lowered or removed altogether.

i. I understand that no agreement can anticipate all events in medical treatment that may arise and that for myself and my heirs, I will hold harmless the prescriber, the practice, the clinic, its officers, owners and staff for all resultant problems. By my signature below, I agree to all the above terms both explicit and implicit.

Patient (or Parent/Guardian) Signature	*Date*
Prescriber Signature	*Date*

Staff Please Note: A copy of this agreement should be provided to the patient upon signing.

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RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ Telephone #: _____

_____

AUTHORIZATION:
I hereby authorize AMM Healthcare to release/disclose the above named individual's health information to. **NOTE if the number of pages is 25 or more than they need to be mailed to**:

RELEASE FROM:
Name (Agency):_____
Address:_____
_____
Phone: ( ) _____
Fax: ( )_____

RELEASE TO:
Name (Agency): AMM Healthcare Medical Records
Address:

Phone:
Fax:

Information to be released/ disclosed:
_____ Entire Health Record _____ Office Visits _____ Reports (Labs, X-Ray, etc) _____Medications _____ Imm Record
Specific Dates of Service: _____

Please produce records via: _____ Mail _____Fax _____ Pick Up

PURPOSE:
_____ Continuity of Medical Care
_____ Insurance or Other Third Party Reimbursement
_____ Not satisfied with medical care
_____ Other (Specify) _____
_____ Disability
_____ Pending Legal Action
_____ Moving out of the area

I understand that the information in my medical record may include information relating to sexually transmitted disease and/or acquired immunodeficiency syndrome (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. I understand that by signing this authorization I am authorizing the release of such information unless specified otherwise above. **A fee will be associated with copying/printing documentation from your medical record for personal use.**

RESTRICTIONS:
According to the Federal and State regulations, if the medical information requested relates to AIDS/ HIV treatment or treatment in a federally recognized chemical dependency unit then the information will be accompanied with a statement limiting disclosure to third parties as required by law.
I understand that if the person or the entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
I realize that although the AMM Healthcare has the responsibility to maintain the confidentiality of the medical records in its possession, I understand that once the information is disclosed the recipient may redisclose it and federal privacy laws or regulations may not protect the information. AMM Healthcare will not be held responsible for any subsequent disclosure by the recipient of the health information. I release the AMM Healthcare of any liability, which may arise as a result of any subsequent disclosure of my personal health information by the recipient.
I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility of benefits.
I have read and understand AMM Healthcare policy on releasing my personal health information.

DURATION:
This authorization will remain valid until _____. I understand that I have a right to revoke this authorization at any time by submitting a written revocation to AMM Healthcare.

SIGNATURE:
Patient Signature: _____ Date: _____

Personal/ Legal Representative Signature: _____

If signed by Personal/ Legal Representative, relationship to Patient: _____

AMM Healthcare Representative: _____ Date: _____

Welcome to AMM Healthcare

AMM Healthcare

Our practice strives to provide quality health care for the entire family and is committed to building a strong doctor-patient relationship that is proactive and comprehensive, while providing access to care through are various locations and on-call services. We are committed to being a Patient-Centered Medical Home (PCMH), for Pediatric and Adult Patients, which is an innovative program for improving primary care.

What is PCMH?

A "Patient-Centered Medical Home" (PCMH) is how health care is delivered to patients. The medical home team at AMM Healthcare manages care and services for you – acting as the "hub" of your health care. PCMH puts you, the patient, at the center of the health care system, and provides primary care that is Accessible, Continuous, Comprehensive, Family-Centered, Coordinated and Compassionate.

Our Responsibilities to You:

•To listen to your questions and concerns and to explain disease, treatment, and results in an easy to understand way. To provide you access to "Evidence-Based Care," educational materials regarding your condition and self-management support.
•To coordinate your overall care across the complex healthcare system, sending you to a trusted specialist if necessary and following up on the healthcare services you receive.
•To provide you with same day appointments whenever possible.
•To provide instructions on how to access the care you need when the office is not open and to be available to you after-hours.
•To provide clear instructions about your treatment goals and future plans for every visit.

Your Responsibilities to a PCMH:

•To ask questions and be active in your care.
•To provide your health history, and other important information, including any changes in your health.
•To call our office first with your health concerns unless it is an emergency.
•To inform us whenever you utilize any other health system such as the emergency room or a self-referral to a specialist.
•To have a clear understanding about your treatment goals and future health goals.

Information about our specialty services, clinic locations and hours of operation can be found on our website at www.ammhealthcarepa.com.

Let us work together to help you live a healthy life by "Promoting a Healthier Future". We look forward to meeting you!

Sincerely,
AMM Healthcare

AMM Healthcare

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED BY JCMC AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

YOUR RIGHTS: When it comes to your health information you have certain rights. This section explains your rights. Upon written request:

- Ask to see or get an electronic or a paper copy of your health record or other information we have about you. We will also provide a summary of your health information if requested. We will charge a reasonable, cost based fee. We will provide this information as soon as possible but no later than 30 working days of the request.
- Ask us to correct your health information you think is incorrect or incomplete. We may say "no" but will tell you why in writing within 60 days.
- You can ask us to communicate with you in a certain way (for example, home or office phone) or to send mail to a different address. We will accommodate all reasonable requests.
- Ask us not to use or share certain health information for treatment, payment or our operations. We are not required to agree with your request and may say "no" if it would affect your care.
- If you pay for a service or health care item out of pocket in full and you ask us not to share that information for payment or our operations with your health insurer we will agree unless we are required by law to share that information.
- Ask us for a list or an accounting of the times we have shared your health information for reasons other than treatment, payment, healthcare operations, and when you have asked us to share information. We will provide a list for the past six years for the request. One request per year will be provided free of charge. For additional requests we will charge a reasonable, cost based fee.
- Revoke an authorization to use or disclose PHI at any time except where action has already been taken.

You may also:

- Choose someone to act on your behalf. If you have given someone medical power of attorney or they are your legal guardian, that person can exercise your rights and make choices about your health information. We will ask for proof of this relationship before we take any action.
- Ask for a paper copy of this document even if you have agreed to receive the notice electronically. We will provide that copy promptly.
- File a complaint if you feel your rights have been violated you may contact the designated Privacy Officer, Rick Fritter, 118 Memorial Dr, Jacksonville NC 28546, 910-219-8333 and rfritter@jcmcpa.net.
- File a complaint with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, S.W., Washington, D.C. 20201, calling 1.877.696.6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.
- We will not retaliate for filing a complaint.

OUR RESPONSIBILITIES: The law requires us to:

- Maintain the privacy and security of your protected health information.
- Notify you promptly if a breach occurs that may compromise the privacy or security of your information.
- Follow the duties and privacy practices described in this notice and give you a copy of it.
- We do not treat minor patients (under 18) without the parent or guardian present with or without a note unless the 5 "protected" areas: Mental Health, STD, Birth control, Abuse, Drug related visits.
- Not to use or share you information other what is described in this notice unless you tell us we can in writing. If you tell us we can and then change your mind, just let us know in writing you have changed your mind.

YOUR CHOICES - For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in situations described below, talk to us.

- In these cases you have both the right and the choice to tell us to: share information with your family, close friends, or others involved in your care and share information in a disaster relief situation.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- In these cases we never share your information unless you give us written permission:
- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes
- In the case of fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURE – We typically use or share your health information in the following ways:

Treatment: We can use your health information and share it with other professionals who are treating you. Example: we may share your health information to an outside doctor for referral. We will also provide your health care providers with copies of various reports to assist them in your treatment.

Payment: We can use or share your health information to bill and get payment from health plans or other entities. Example: we give information about you to your health insurance plan so it will pay for your healthcare.

Health Care Operations: We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: we use health information about you to manage your treatment and services.

Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care. You can "opt out" of the Health Information Exchange by going to www.coastalconnect.org, opt out of NCHIE by going to https://hiea.nc.gov/documents/opt-out-form-english or by speaking with our Patient Advocate.

Medication History: We may check your medication history electronically through SureScripts to ensure your safety, as well as to prevent diversion and the abuse of prescription medications. You can opt-out of this history review by submitting to us in writing, your lack of consent.

Other ways we can use or share your health information – We are allowed or required to share you information in other ways – **usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.**

- **Help with public health and safety issues:** We can share health information about you for certain situations such as: preventing disease, helping with product recalls, reporting adverse reactions to medication, reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious threat to anyone's health and safety.
- **Comply with the law**: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see if we are complying with federal privacy law.
- **Respond to organ and tissue donation requests:** We will share health information about you with organ procurement organizations.
- **Work with a medical examiner or funeral director:** We can share health information with a coroner, medical examiner, or funeral director when you die.
- **Address workers' compensation, law enforcement, and other government requests:**
    - For workers' compensation claims
    - For law enforcement purposes or with a law enforcement official
    - With health oversight agencies for activities authorized by law
    - For special government functions such as military, national security, and presidential protective services
- **Respond to lawsuits and legal actions:** We can share your health information to respond to a court or administrative order, or in response to a subpoena.
- **Research:** We can use or share your information for health research.

CHANGES TO THIS NOTICE - We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our website https://ammhealthcarepa.com .

Effective date: 13 August 2018 Revision Date: 4 Apr 2019