

PEACHFORD HOSPITAL

Parent and Guardian Information for Children and Adolescents

Mother's Name: _____

Address: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Social Security #: _____

Drivers License #: _____

Date of Birth: _____

Father's Name: _____

Address: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Social Security #: _____

Drivers License #: _____

Date of Birth: _____

Guardian's Name: _____

Address: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Social Security #: _____

Drivers License #: _____

Date of Birth: _____

Who has legal custody? _____

Who does the child or adolescent live with? _____

Please bring in copies of Custody and Legal Documents

PEACHFORD HOSPITAL

Communicable Disease Questionnaire

Patient Identification

Name: _____ Date: _____

Brief questionnaire is a screening tool to help identify possible communicable diseases

1. Do you currently have or have you ever had:

- Measles No Yes
- Mumps No Yes
- Rubella No Yes
- Chicken Pox No Yes
- Hepatitis No Yes
- HIV No Yes
- Tuberculosis No Yes
- Other No Yes

2. If the answer to any of the above is yes, please list dates _____

3. Are you now under the care of a physician or taking any medication for a communicable disease? No Yes
If yes, please explain _____

4. Have you had recent contact with someone with any of the above illnesses? No Yes
If yes, which one(s):

5. Have you ever been tested for Tuberculosis? No Yes If yes, when? (Date): _____

6. Have you ever tested positive for TB? No Yes
If yes, did you have a chest x-ray? No Yes
Were you treated? No Yes If yes, when? (Date): _____

7. Please check **yes** or **no** to **ALL** symptoms as they apply to you:

- Productive Cough (3 weeks or more) No Yes
- Persistent Weight Loss without dieting No Yes
- Persistent Low Grade Fever No Yes
- Night Sweats No Yes
- Loss of Appetite No Yes
- Swollen Glands, usually in the Neck No Yes
- Recurrent Kidney Infections No Yes
- Shortness of Breath No Yes
- Chest Pain No Yes

STAFF USE ONLY - After review of answers, what actions have been taken:

Reviewed By: _____ Date & Time: _____

Peachford Hospital

Authorization to Release and Obtain Information

Patient Name:	
Medical Record Number:	Admit Date:

Purpose of Disclosure: Continuity of patient care for adequate follow-up of treatment for chemical dependency and/or mental condition, and acknowledge of the referral.

The undersigned acknowledges that disclosure may be either verbal, review of the patient's medical record, or release of photocopies of reports from the patient's medical record which may consist of diagnosis, treatment progress updates, continuing of care plans, psychological history and discharge summary.

The undersigned certifies that he/she read the foregoing, that it has been fully explained and that he/she understands its contents. The undersigned acknowledges that he/she has consented voluntarily and that the consent is valid for this admission only and shall expire 180 days after patient discharge.

School

Do not have a school

Address / Phone Number

Do not contact School

Primary Care Physician (PCP)

Do not have a PCP

Agency / Address / Phone Number

Do not contact PCP

Psychiatrist

Do not have a Psychiatrist

Agency / Address / Phone Number

Do not contact Psychiatrist

Therapist

Do not have a Therapist

Agency / Address / Phone Number

Do not contact Therapist

Employer

Do not have an Employer

Agency / Address / Phone Number

Do not contact Employer

Referral Source

Do not have a Referral Source

Agency / Address / Phone Number

Do not contact Referral Source

Other

Do not have any others

Agency / Address / Phone Number

Do not contact other

Signed this _____ day of _____, _____ at _____ (time)

Signature of Patient or Legal Guardian

Signature of Staff Witness

PEACHFORD HOSPITAL

Coordination of Benefits Questionnaire

DATE: _____

**** PLEASE FILL OUT COMPLETELY & ACCURATELY. THIS IS A TWO PAGE FORM****

PATIENT NAME (FIRST, MI, LAST)

SOCIAL SECURITY NUMBER

ADDRESS

APARTMENT NUMBER

CITY

STATE

ZIP CODE

COUNTY

MARITAL STATUS

DATE OF BIRTH

AGE

SEX

GUARDIAN/SPOUSE

HOME PHONE #

MAY WE CALL YOU

WORK PHONE #

MAY WE CALL YOU

()

AT HOME? YES__NO__

()

AT WORK YES__NO__

EMERGENCY CONTACT INFORMATION:

NAME: _____ RELATIONSHIP: _____

COMPLETE ADDRESS:

HOME PHONE #: ()

WORK PHONE # ()

CELL # ()

COORDINATION OF BENEFITS QUESTIONNAIRE

IS THE PATIENT COVERED UNDER MEDICARE: YES _____ NO _____

IF YES, WHAT IS THE EFFECTIVE DATE OF MEDICARE PART A: _____

****MEDICARE CLIENTS MUST COMPLETE MEDICARE AS SECONDARY PAYER FORM****

IS THE PATIENT THE SUBSCRIBER**? YES _____ NO _____

**THE SUBSCRIBER IS THE POLICYHOLDER, I.E. THE EMPLOYEE THAT CARRIES THE PLAN

IF NO, WHAT IS THE RELATIONSHIP OF THE SUBSCRIBER TO THE PATIENT?

SPOUSE _____ PARENT _____ OTHER (EXPLAIN): _____

PLAN INFORMATION:

NAME OF PLAN: _____ EFF DATE: _____

ID#: _____ GROUP #: _____

INSURANCE COMPANY PHONE NUMBER: _____

SUBSCRIBER INFORMATION IF NOT THE PATIENT:

NAME: _____ DOB: _____

ADDRESS: _____

SOCIAL SECURITY NUMBER: _____ TELEPHONE # _____

EMPLOYER INFORMATION:

EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____

EMPLOYER TEL #: _____ EFF DATE OF EMPLOYMENT: _____

IS THE SUBSCRIBER CURRENTLY EMPLOYED: YES _____ NO _____

INITIALS: _____

IS THE PATIENT COVERED UNDER ANY OTHER PLAN? YES _____ NO _____
IF YES, PLEASE PROVIDE OTHER INSURANCE INFORMATION:

PLAN INFORMATION:

NAME OF PLAN: _____ EFF DATE: _____
ID#: _____ GROUP #: _____
INSURANCE COMPANY PHONE NUMBER: _____

SUBSCRIBER INFORMATION IF NOT THE PATIENT:

NAME: _____ DOB: _____
ADDRESS: _____
SOCIAL SECURITY NUMBER: _____ TELEPHONE # _____

EMPLOYER INFORMATION:

EMPLOYER NAME: _____
EMPLOYER ADDRESS: _____
EMPLOYER TEL #: _____ EFF DATE OF EMPLOYMENT: _____
IS THE SUBSCRIBER CURRENTLY EMPLOYED: YES _____ NO _____

I CERTIFY THAT _____ IS THE PRIMARY CARRIER DUE TO:
NAME OF PRIMARY INSURANCE

_____ I AM THE SUBSCRIBER THROUGH MY EMPLOYER

_____ BIRTHDAY RULE

_____ OTHER: _____

****I GIVE PERMISSION TO PEACHFORD HOSPITAL TO CONTACT MY EMPLOYER TO VERIFY THAT MY COVERAGE IS IN EFFECT****

SIGNATURE OF PATIENT/GUARANTOR: _____ **DATE:** _____

PEACHFORD HOSPITAL

Patient Intake - Medical Status Questionnaire

How did you hear about Peachford Hospital? _____

Areas of Concern (Check *if* Yes)

- Alcohol use or abuse
- Drug use or abuse
- Overdose
- Suicidal thoughts *currently*
- Suicidal thoughts *in the past*
- Suicidal attempts
- Feelings of wanting to hurt others
- Feelings that others are out to get you
- Feelings of anger
- Hearing things others do not hear
- Seeing things others do not see
- Thoughts which are hard to get rid of
- Unwanted thoughts

- Allergies: _____

Areas of Concern (Check *if* Yes)

- Rapid breathing
- Rapid heart rate
- Tremors
- Chest pain
- Cardiac Disease/Hypertension
- Chest Pain
- CVA or Stroke
- Seizure disorder
- Diabetes
- Asthma/COPD/Difficulty Breathing
- HIV / AIDS
- Brain Injury
- GI Dysfunction/Incontinence
- Open Wound/Sutures/Active Bleeding
- Pregnant

What recent events or problems brought about your request for help today?

Is there anything else you would like to explain?

Staff Use Only

Reviewed by: _____ Date & Time _____

Reviewed with MD/Nurse (as indicated): _____ Date & Time _____

MEDICARE SECONDARY PAYER QUESTIONNAIRE

Patient Name: _____

HIC Number: _____

PART I

Are you receiving Black Lung (BL) benefits? BL is primary only for claims related to BL.

_____ Yes. Date benefits began (month/day/year) _____ No _____

Are the services to be paid by a government program such as a research grant?

_____ Yes; Government Program will pay primary benefits for those services No _____

Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?

_____ Yes. DVA is primary for these services No _____

Was the illness/injury due to a work related accident/condition?

_____ Yes; date of injury/illness (month/day/year) _____ Policy or ID number: _____

WC is primary payer only for claims related to work related injuries or illness. Go to PART III.

Name and address of WC plan:

Name and address of your employer:

_____ No. **GO TO PART II**

PART II

Was illness/injury due to a non-work related accident?

_____ Yes; date of accident (month/day/year): _____ No _____ **GO TO PART III**

What type of accident caused the illness/injury? _____ Automobile or _____ Non-automobile

Name and address of no-fault or liability insurer: _____ Insurance Claim number: _____

No-fault insurer is primary payer only for those claims related to the accident. GO TO PART III

Was another party responsible for this accident?

_____ Yes. **Liability insurer is primary only for those claims related to the accident. GO TO PART III**

Name and address of any liability insurer: _____ Insurance claim number: _____

_____ No. **GO TO PART III**

PART III

Are you entitled to Medicare based on:

_____ Age **GO TO PART IV** _____ Disability. **GO TO PART V** _____ ESRD. **GO TO PART VI**

PART IV – AGE

1. Are you currently employed?

_____ Yes _____ No

Date of retirement: _____

Name and address of your employer:

2. Is your spouse currently employed?

_____ Yes _____ No

Date of retirement: _____

Name and address of employer:

IF PATIENT ANSWERED NO TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II. DO NOT PROCEED ANY FURTHER.

Do you have group health plan (GHP) coverage based on your own, or a spouse's current employment? ___ Yes ___ No. **Stop. Medicare is primary payer unless the patient answered yes to the questions in Part I or II.**

Does the employer that sponsors your GHP employ 20 or more employees?

Yes. **Stop. Group Health Plan is primary. Obtain the following information.**

Name and address of GHP:

Policy identification number: _____

Group identification number: _____

Name of policyholder: _____

Relationship to patient: _____

No. **Stop. Medicare is primary payer unless the patient answered Yes to the questions in Part I or II.**

Part V Disability

1. Are you currently employed?

Yes No Date of retirement: _____

Name and address of your employer:

2. Is a family member currently employed?

Yes No

Name and address of employer:

If the patient answered No to both questions 1 and 2, Medicare is primary unless the patient answered Yes to Questions in Part I or II. Do not proceed any further.

Do you have group health plan (GHP) coverage based on your own, or a spouse's current employment?

Yes No. **Stop. Medicare is primary payer unless the patient answered Yes to the questions in Part I or II.**

Does the employer that sponsors your GHP employ 100 or more employees?

Yes. **Stop. Group Health Plan is primary. Obtain the following information.**

Name and address of GHP:

Policy identification number: _____

Group identification number: _____

Name of policyholder: _____

Relationship to patient: _____

No. **Stop. Medicare is primary payer unless the patient answered Yes to the questions in Part I or II.**

Part VI ESRD

Do you have group health plan (GHP) coverage?

Yes

Name and address of GHP:

Policy identification number: _____

Group identification number: _____

Name of policyholder: _____

Relationship to patient: _____

Name and address of employer, if any, from which you receive GHP coverage:

No. **Stop. Medicare is primary.**

Have you received a kidney transplant?

Yes; date of transplant (please enter month/day/year): _____ No

Have you received maintenance dialysis treatments?

Yes. Date of dialysis began (please enter month/day/year): _____ No

If you participated in a self dialysis-training program, provide date training started (please enter month/day/year): _____

Are you within the 30-month coordination period?

Yes No. **Stop. Medicare is primary.**

Patient Name:
Patient ID Number:
Physician:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
OMB Approval No. 0938-0692

AN IMPORTANT MESSAGE FROM MEDICARE ABOUT YOUR RIGHTS

AS A HOSPITAL INPATIENT, YOU HAVE THE RIGHT TO:

- Receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.
 - Be involved in any decisions about your hospital stay, and know who will pay for it.
 - Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here Georgia Medical Care Foundation-404-982-0411.
-

YOUR MEDICARE DISCHARGE RIGHTS

Planning For Your Discharge: During your hospital stay, the hospital staff will be working with you to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.

If you think you are being discharged too soon:

- You can talk to the hospital staff, your doctor and your managed care plan (if you belong to one) about your concerns.
- You also have the right to an appeal, that is, a review of your case by a Quality Improvement Organization (QIO). The QIO is an outside reviewer hired by Medicare to look at your case to decide whether you are ready to leave the hospital.
 - **If you want to appeal, you must contact the QIO no later than your planned discharge date and before you leave the hospital.**
 - If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
- If you do not appeal, but decide to stay in the hospital past your planned discharge date, you may have to pay for any services you receive after that date.
- **Step by step instructions for calling the QIO and filing an appeal are on page 2.**

To speak with someone at the hospital about this notice, call the Patient Advocate.

Please sign and date here to show you received this notice and understand your rights.

Signature of Patient or Representative

Date

STEPS TO APPEAL YOUR DISCHARGE

- **STEP 1:** You must contact the QIO no later than your planned discharge date and before you leave the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
 - Here is the contact information for the QIO:
Georgia Medical Care Foundation
404-982-0411
 - You can file a request for an appeal any day of the week. **Once you speak to someone or leave a message, your appeal has begun.**
 - Ask the hospital if you need help contacting the QIO.
 - The name of this hospital is _____ {insert the name of the hospital and the provider ID number}.
- **STEP 2:** You will receive a detailed notice from the hospital or your Medicare Advantage or other Medicare managed care plan (if you belong to one) that explains the reasons they think you are ready to be discharged.
- **STEP 3:** The QIO will ask for your opinion. You or your representative need to be available to speak with the QIO, if requested. You or your representative may give the QIO a written statement, but you are not required to do so.
- **STEP 4:** The QIO will review your medical records and other important information about your case.
- **STEP 5:** The QIO will notify you of its decision within 1 day after it receives all necessary information.
 - If the QIO finds that you are not ready to be discharged, Medicare will continue to cover your hospital services.
 - If the QIO finds you are ready to be discharged, Medicare will continue to cover your services until noon of the day after the QIO notifies you of its decision.

IF YOU MISS THE DEADLINE TO APPEAL, YOU HAVE OTHER APPEAL RIGHTS:

- You can still ask the QIO or your plan (if you belong to one) for a review of your case:
 - If you have Original Medicare: Call the QIO listed above.
 - If you belong to a Medicare Advantage Plan or other Medicare managed care plan: Call your plan.
- If you stay in the hospital, the hospital may charge you for any services you receive after your planned discharge date.

For more information, call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048.

Additional Information:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0692. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.