Mosaic Health Center
Health Insurance and Income Verification Form

I,_____(name)

currently residing at_____(address)

attest that:

- I currently do not have **medical or vision insurance of any kind** (Medicaid, Medicare, private insurance, ACA insurance, or any other types of health insurance)

  OR

- I am **underinsured with limited benefits** such as coverage only for preventive and emergency care and no coverage for prescription medications. My insurance does not give me access to primary care services because the co-pay and/or deductible are unaffordable for me and/or because they do not cover the services I need.

Therefore, I am eligible to receive care at Mosaic Health Center. I further understand that Mosaic Health Center provides services to individuals living at or below 300% Federal Poverty level (FPL).

Please provide the number of dependents in your household (include self/ spouse): _____

Please provide the gross monthly income from all sources: _____

I attest that the above information is accurate and true.

_____
Signature

_____
Printed Name

_____
Date

Patient Means of Communication

I agree that Mosaic Health Center (MHC) can contact me using the following methods regarding my personal health information, evaluation and treatment. I authorize/do not authorize MHC to leave messages for me when I am unavailable as indicated below.

Check to Confirm Approval of Method	Number/Address	Leave Messages
● Home Phone	(_____)_____-_____	● Yes ● No
● Cell Phone	(_____)_____-_____	● Yes ● No
● Text to Cell Phone	(_____)_____-_____	● Yes ● No
● Alternate Phone	(_____)_____-_____	● Yes ● No
● E-mail	_____	● Yes ● No

I authorize MHC to discuss my personal health information with the individuals listed below. I understand that by leaving spaces blank, I am indicating my choice that I do not want my information shared with or released to anyone else.

Name	Relationship to Patient	Phone Number
	_____	(_____)_____-_____
	_____	(_____)_____-_____
	_____	(_____)_____-_____

By my signature below, I hereby acknowledge that I have read and understand the information provided on this Consent Form. I understand the risk associated with different methods of communication, especially email, and consent to the communications outlined in this Consent Form.

Patient Name Printed_____ Date _____

Patient/Authorized Signature _____

PATIENT INFORMATION FORM

Patient Name: _____

Patient Date of Birth: _____ Today's Date: _____

Address: _____

Cell Phone:_____Home phone:_____E-mail: _____

Social Security Number:_____ Primary Language: _____

Do you speak English? (circle): **YES** **NO** **SOME** How long have you been in the U.S.? _____

What country are you from?_____ Race: _____

Marital Status (circle): **SINGLE** **MARRIED** **DIVORCED** **WIDOWED**

Education (circle): **NONE** **PRIMARY** **SECONDARY (middle or high school)** **UNIVERSITY** **OTHER**

_____

Employment (circle)**:** **UNEMPLOYED** **PART-TIME** **FULL-TIME** **STUDENT**

INTAKE/HISTORY FORM

Patient Name (Last, Middle, First):_____Date: _____

Male or Female: _____ DOB: _____ Age:_____Language: _____

PATIENT MEDICAL HISTORY (Please describe both current and previous):

Ongoing Medical Problems (Check all that apply) ○ Check here if none ○ Headaches ○ Ear/Nose/Throat problems ○ Asthma/Breathing problems ○ Heart problems ○ High blood pressure ○ High cholesterol ○ Diabetes ○ Other (please describe below)	**Social History** (Check all that apply) ○ Smoking/tobacco/chew ○ If yes, how often _____ ○ If yes, for how many years _____ ○ Paan/betel ○ If yes, how often _____ ○ If yes, for how many years _____ ○ Alcohol (beer, wine, spirits) ○ If yes, how often _____ ○ If yes, for how many years _____ ○ Recent travel ○ If yes, where _____
Major Events (Hospitalization, surgery, giving birth, etc.) Please describe or write "none."	**Family Health History** (Check & write family members) ○ Diabetes ○ High blood pressure ○ Heart problems ○ Stroke ○ Cancer (circle): breast, ovarian, colon, other _____ ○ Mental health issues (circle): depression, anxiety, post-traumatic stress, other _____ ○ Other _____
Are you allergic to any medications? If so, please list them (or write "none"):	**Nutrition** Please describe the types of foods you usually eat.

CURRENT MEDICATIONS/DOSAGES (include over-the-counter and herbs)

Medication	Dose

MOSAIC HEALTH CENTER
3700 Market Street, Suite E1, Clarkston, GA 30021 Phone: (678) 383-1383

Mosaic Health Center
Patient Rights and Responsibilities

Patient Rights

1. A patient has the right to respectful care from qualified providers.
2. A patient has the right to know the names and roles of the medical staff.
3. A patient has the right to privacy about their medical condition. Only people who need to know will talk about the patient's care. Information about a patient will only be shared if the patient agrees or if the law requires it.
4. A patient has the right to ask for changes to their health records and to know who has looked at them.
5. A patient has the right to know the rules and policies of Mosaic Health Center (MHC) while they are a patient.
6. A patient has the right to good quality care that is regularly reviewed.
7. A patient has the right to make decisions about their care, including involving family members.
8. A patient has the right to get information from their doctor in a way they can understand. This includes information about their diagnosis, treatment options, and what to expect. In emergencies, this might not be possible.
9. If a patient is asked to join a research study, they have the right to full information and can refuse to participate. If they join, they can stop at any time without it affecting their care.
10. A patient has the right to refuse any medication, treatment, or procedure after being told the risks.
11. A patient has the right to get a second opinion from another doctor at their own cost.
12. A patient has the right to receive care no matter their race, religion, disability, gender, sexual orientation, nationality, or how they pay.
13. A patient has the right to information they can understand. If a patient doesn't speak English or has a hearing or speech problem, they have the right to an interpreter, if available.
14. A patient has the right to see their medical records within a reasonable time. The doctor can limit access only for valid medical reasons, but the patient has the right to have the information explained.
15. A patient has the right not to go through unnecessary medical or nursing procedures.
16. A patient has the right to receive treatment that avoids unnecessary discomfort.
17. A patient has the right to receive a copy of their bills and have them explained.
18. A patient has the right to get help with finding ways to pay their medical bills.
19. A patient has the right to assistance with planning for discharge and understanding how to continue care after leaving the facility.
20. A patient has the right to contact people or agencies to act on their behalf or to protect their rights under the law. If the patient or their family feels unsafe, they have the right to contact protective services.
21. A patient has the right to be informed of their rights as soon as possible during their treatment.
22. A patient has the right to make advance directives, like a living will or health care power of attorney, and have those directives followed as allowed by law.

23. A patient has the right to personal privacy and to be cared for in a safe environment.
24. A patient has the right to be free from any kind of abuse or harassment.
25. A patient has the right to be free from restraints or isolation, unless a doctor orders them for safety. Restraints will only be used as a last option and will be removed as soon as possible.
26. A patient has the right to choose visitors, who will have the same visitation rights as family members, even if they are not legally related.
27. A patient has the right to pastoral care and other spiritual services.
28. A patient has the right to be part of resolving difficult decisions about their care.
29. A patient has the right to have any complaints about their care addressed.
30. A patient and their family have the right to ask for help from the ethics committee when there are issues like starting or stopping life-support treatments or disagreements about care.
31. A patient has the right to receive proper pain management.
32. A patient has the right to be protected from financial abuse by the healthcare facility.

Patient Responsibilities

1. Patients must give correct and complete information about their health and past medical history.
2. Patients must tell their providers about any changes in their health, symptoms, or allergies.
3. Patients must ask questions if they do not understand the treatment or their role in the care plan.
4. Patients must follow the treatment plan they agreed to, including instructions from other health workers.
5. Patients must keep their appointments.
6. Patients must treat others with respect.
7. Patients must follow the facility's rules about smoking, noise, and using electrical equipment.
8. Patients are responsible for what happens if they refuse the treatment plan.
9. Patients must pay for their care.
10. Patients must respect other people's property and rights.
11. Patients must help control noise and limit the number of visitors in their rooms.
12. Patients understand that MHC is a primary care clinic and does not provide emergency or urgent care services.

_____

Print Name

_____

Signature

_____

Date

NOTICE OF PRIVACY PRACTICES
Mosaic Health Center
Effective Date: 09/03/2024

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

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate Mosaic Health Center properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Operational Director Officer listed below.

How Mosaic Health Center May Use or Disclose Your Health Information

Mosaic Health Center (MHC) collects health information about you and stores it in a chart, on a computer and in an electronic health record/personal health record. This is your medical record. The medical record is the property of MHC, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.
2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.
3. Health Care Operations. We may use and disclose medical information about you to operate MHC. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.
4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.
5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.
9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.
12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.
15. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
16. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.
17. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
18. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
19. Change of Ownership. In the event that MHC is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
20. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.
21. Psychotherapy Notes. We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: 1) use by the originator of the notes for your treatment, 2) for training our staff, students and other trainees, 3) to defend ourselves if you sue us or bring some other legal proceeding, 4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, 5) in response to health oversight activities concerning your psychotherapist, 6) to avert a serious and imminent threat to health or safety, or 7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy

notes, we will stop using or disclosing these notes.

22. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

23. Fundraising. We may use or disclose your demographic information in order to contact you for our fundraising activities. For example, we may use the dates that you received treatment, the department of service, your treating physician, outcome information and health insurance status to identify individuals that may be interested in participating in fundraising activities. If you do not want to receive these materials, notify the Privacy Officer listed at the top of this Notice of Privacy Practices and we will stop any further fundraising communications. Similarly, you should notify the Privacy Officer if you decide you want to start receiving these solicitations again.

When Mosaic Health Center May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, Mosaic Health Center will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize MHC to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about MHC's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by MHC except that MHC does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent MHC has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Operational Director listed at the bottom of this Notice of Privacy Practices.

Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. **Complaints**

Complaints about this Notice of Privacy Practices or how MHC handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Berthe Jean-Jacques

berthej@mosaichealthcenter.com

NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT

I_____(print name) have had the opportunity to review the Mosaic Health Center Notice of Privacy Practices. I acknowledge a copy will be provided to me upon my request.

_____ _____

Signature of Patient Date