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 BEHAVIORAL HEALTH SYSTEM OF ATLANTA
COORDINATION OF BENEFITS QUESTIONNAIRE

***** Please Fill Out Completely and Accurately *****

Patient Name: _____ Social Security Number:_____
Address:_____City:_____State:_____Zip Code:_____
Marital Status:_____ Date of Birth_____ Age: ___ Sex: ____ Guardian:_____
Home Phone #:_____ Work Phone #:_____ Cell Phone #:_____

Emergency Contact Information:
Name: _____ Relationship:_____
Address:_____City:_____State: _____Zip Code:_____
Phone number: Home:_____ Work:_____ Cell phone:_____

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 Attached

Primary Insurance:

Is The Patient The Subscriber (The Subscriber is the employee that carries the plan): Yes:____ No:_____
If No, What Is The relationship Of The Subscriber To The Patient: Spouse___ Parent___ Other_____

Plan Information:
Name of Plan: _____ Effective Date:_____
ID #: _____ Group #: _____
Insurance Company Phone Number: _____

Subscriber Information If Not The Patient:
Name:_____ Date of Birth: _____
Address: _____City:_____State:_____Zip Code:_____
Social Security Number: _____ Telephone Number: _____

Employer Information:
Employer Name: _____
Employer Address:_____
Employer Phone #: _____ Effective Date of Employment: _____
Is The Subscriber Currently Employed? Yes: _____ No: _____

Initials of Patient/Guarantor: _____

COORDINATION OF BENEFITS QUESTIONNAIRE

Is The Patient Covered Under Any Other Insurance Plan? Yes_____ No _____
If Yes, Please Provide Other Insurance Information:

Secondary Insurance Plan Information:

Name of Plan:_____ Effective Date:_____
ID # _____ Group # _____
Insurance Company Phone Number: _____

Subscriber Information If Not The Patient:

Name: _____ DOB: _____
Address:_____City:_____State:_____Zip Code:_____
Social Security Number: _____ Telephone #: _____

Secondary Employer Information:
Secondary Employer Name: _____
Secondary Employer Address:_____
Secondary Employer Phone #: _____
Is The Subscriber Currently Employed: Yes: _____ No: _____

I Certify That _____ Is The Primary Carrier Due To:

_____ I Am The Subscriber Through My Employer
_____ Birthday Rule
_____ Other: _____

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:

Patient Intake / Medical Status Questionnaire Page 2

How often do you have a drink containing alcohol? *(Select one response.)*

- ☐ Never (0)
- ☐ Monthly or less (1)
- ☐ 2-4 times a month (2)
- ☐ 2-3 times a week (3)
- ☐ 4 or more times a week (4)

How many drinks containing alcohol do you have on a typical day when you are drinking? *(Select one response.)*

- ☐ 1 or 2 (0)
- ☐ 3 or 4 (1)
- ☐ 5 or 6 (2)
- ☐ 7 to 9 (3)
- ☐ 10 or more (4)

How often do you have six or more drinks on one occasion? *(Select one response.)*

- ☐ Never (0)
- ☐ Less than monthly (1)
- ☐ Monthly (2)
- ☐ Weekly (3)
- ☐ Daily or almost daily (4)

FOR STAFF USE ONLY

Scoring:
Scored on a scale of 0-12. Each question above is scored from 0 to 4 (the scores are in parentheses next to each response).

In men, a score of 4 or more is considered positive for identifying hazardous drinking or active alcohol use disorders. In women, a score of 3 or more is considered positive.

However, if all of the points are from the first question and the second and third question score 0, you should review the patient's alcohol intake over the past few months to confirm accuracy.

Total Score: _____

Reviewed / Scored by: _____ Date / Time: _____