MVC Patient Agreement

Welcome to Macon Volunteer Clinic! We are pleased to have you as a patient.

What to Expect

Macon Volunteer Clinic (MVC) provides free primary medical and dental care, as well as medication assistance, to uninsured, working adult residents of Bibb County, and Twiggs County, Georgia.

As a patient of MVC, you will have access to primary medical care during clinic hours by appointment only. Services include doctor visits, non-narcotic prescription medication, laboratory analyses, eye exams, dental cleanings and extractions, and cancer screenings such as mammograms, Pap smears and colonoscopies. All procedures performed on clinic premises are provided to you free of charge.

If you need to be seen by a specialist, such as a cardiologist or orthopedist, you will be referred to another physician outside of Macon Volunteer Clinic. Many specialists will provide services to you for free or at a reduced cost. If a specialty physician orders a procedure for you, please notify MVC. We may be able to negotiate a reduced fee for you. You are responsible for paying for any medical care you receive outside of MVC.

If you need medical care outside of clinic hours for an urgent medical problem, please go to an Urgent Care facility. In the case of a true medical emergency, please go to the nearest Emergency Room or call 911. There are no MVC doctors on call on nights, weekends, or holidays.

MVC is not private health insurance. Expenses for services provided at any facility other than Macon Volunteer Clinic are your responsibility.

Patient Responsibilities

- You must bring your medications to every doctor visit.
- If you have diabetes, you must bring your glucometer to every doctor visit.
- You will request prescription renewals during doctor visits only. Know when your refills are due.
- You must provide 48 hours' notice when you cancel an appointment.
- You must verify eligibility every year.

Experience proves that our most successful patients are those who are actively involved in their own healthcare.

Prescription Medications

MVC physicians make best efforts to prescribe generic, low-cost medications for you to purchase at your local pharmacy. When possible, prescription medications are provided to our patients free of charge through our Patient Prescription Assistance Program (PPAP).

If you require a renewal of a prescription, you must schedule an appointment with a doctor. Bring all of your medications with you when you see the doctor.

If you require a refill of your medication(s) from the pharmacy, please notify MVC ***at least 48 hours*** before you run out of medication(s).

If you require a refill of PPAP medication(s), please notify the Patient Assistance Coordinator ***at least two weeks*** before you run out of your medication(s). PPAP medications are ordered directly from pharmaceutical companies and may take up to two weeks to receive.

MVC does not refill prescriptions on a walk-in basis.

Macon Volunteer Clinic

Patient Visit Agreement

In the event that you cannot make your appointment at Macon Volunteer Clinic (MVC), please provide 48 hours' notice to cancel or reschedule your appointment. Your courtesy will allow us to see another patient during that appointment time.

If you do not cancel your appointment, within these guidelines,you will be considered a "no-show".

O Three clinic "no-shows" will result in your being discharged from MVC for one year.

O One "no-show" for an appointment with an offsite specialty healthcare provider will result in your being discharged from MVC for one year.

1st Offense: You will receive a verbal warning by phone or in person from MVC staff.

2nd Offense: You will receive a verbal warning by phone or in person by MVC staff.

3rd Offense: A phone call and letter will go out stating you have been discharged from Macon Volunteer Clinic for one year.

On occasion, MVC healthcare providers will request that you go for labs, x-rays, or other diagnostic services at another facility. These services are free. You agree to follow the instructions given by MVC healthcare providers and/or MVC staff before you go for your tests.

If you receive a bill for any services requested by MVC, please bring the bill to the clinic immediately for payment.

Macon Volunteer Clinic Eligibility Requirements

1. You must be actively employed.
2. You must live in Bibb or Twiggs County
3. You must be between the ages of 18-64
4. You must not be eligible for Veterans Administration Benefits or have any active medical coverage which includes health insurance, Medicaid, or Medicare.
5. You must not have an active Medical Center Care Partner card.
6. You **must** provide a current year tax return for you and your spouse.

Eligibility Screenings: Wednesday 2:00-3:30 pm and Friday 9:00 - 11:30 am.

If you meet the eligibility requirements above, you must provide ALL of the required documents before you will be screened. Missing documentation will result in your application being incomplete. Only applicants with complete documentation will receive appointments at the clinic.

_____ **Current year's tax return for you and your spouse. (1040 with W-2 copies attached.)**
_____ Proof you live in Bibb/Twiggs County. (Two current utility bills showing your name and address.)
_____ Picture ID issued by a government agency or employer.
_____ Social Security card.
_____ Legal Alien Card (Green Card) if not a U. S. citizen.
_____ Letter from your employer (and your spouse's employer) stating that you are employed and you do not have health coverage.
_____ Verification of the **past 6 weeks** employment earnings.
_____ If you are self employed, you must provide an up-to-date Profit and Loss statement, as well as your Schedule C.
_____ If there is other income in your household, provide verification. (Child support, SSI, RSDI, alimony, etc.)

- **We check to verify that any dependents listed on your 1040 tax return are not claimed by someone else and have lived in your home and you are responsible for and have provided support for the year claimed.**
- **If you have claimed someone who you do not have the right to claim, you should reconsider applying to this clinic because the tax return is fraudulent.**
- **If during the eligibility screening we find that your claimed dependents are in foster care, claimed by someone else or not eligible to be your dependent, you will not be able to be a patient at this clinic.**
- **Any misleading or false statements made on your application will result in your application being permanently denied.**
- **Your eligibility will be reviewed on a yearly basis.**

I understand that my income will be compared against the GA Department of Labor's Wage, Unemployment Compensation, and New Hires files. My information may be shared with other agencies in order to complete my eligibility process or to help me secure other benefits for which I may qualify. I must apply for all available programs (Medicaid, Medicare, etc.) that I am eligible for.

I give my consent to the GA Department of Human Resources to advise Macon Volunteer Clinic of the status of any application I have made for assistance and/or any discrepancies found in the information I have provided.

Signed _____ Date

Printed Name _____ Phone # _____

Macon Volunteer Clinic

Patient Information Sheet

Patient Name Date of Birth

Address City, ZIP

Home Phone Work phone Cell phone

Please circle best contact phone: Home Work Cell Other _____

Gender

Race

Social Security #

Marital Status

Email Address Preferred Pharmacy_____

Emergency Contact Name and Number

Patient Signature_____ Date

I authorize MVC to discuss my medical condition with the following family members or other individuals:

Sign here if NONE:_____Date

Sign here if YES:_____Date

If yes,please list the names and relationship:

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship

Patient Consent To Treat and Health Information Release

I, _____, hereby acknowledge and understand that by signing this voluntary care Patient Consent Form, I am giving informed consent to the provisions of diagnosis, care and/or treatment by Macon Volunteer Clinic. I authorize Macon Volunteer Clinic to release my health information (information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number) for the purpose of resolving claims and/or securing specialty care. I understand that any personal health information or other information released to a third party may be subject to re-disclosure by the third party and may no longer be protected by applicable federal or state privacy laws. This authorization is valid from the date of my signature below. I understand that I have a right to revoke this authorization by providing written notice to Macon Volunteer Clinic. However, this authorization may not be revoked if Macon Volunteer Clinic has taken action on this authorization prior to receiving my written notice. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not impact my eligibility for primary medical care at Macon Volunteer Clinic.

_____ _____

Patient Signature Date

NAME: Date of Visit:

Last First Middle

DOB:

MACON VOLUNTEER CLINIC
PATIENT MEDICAL HISTORY

Why have you come to see the doctor today?

INSTRUCTIONS: This is not a quiz. Please check all that apply. Answer the following questions to the best of your memory. Do not worry yourself as to whether your answers are exactly correct. Dates only need to be approximate. If you need help filling out this information, please let us know.

MEDICAL HISTORY:

Diabetes	☐No	☐Yes	Bleeding Tendency	☐No	☐Yes
High Blood Pressure	☐No	☐Yes	Acute Infections	☐No	☐Yes
Cancer	☐No	☐Yes	Hereditary Defects	☐No	☐Yes
Stroke	☐No	☐Yes	Depression	☐No	☐Yes
Heart Trouble	☐No	☐Yes	HIV	☐No	☐Yes
Arthritis/Gout	☐No	☐Yes	Hepatitis	☐No	☐Yes
Seizures/Epilepsy	☐No	☐Yes	If yes, circle: A B C		

SOCIAL HISTORY:

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Use of Alcohol: ☐Never ☐Rarely ☐Moderate ☐Daily

Use of Tobacco: ☐Never ☐Previously, but quit ☐Daily (If daily, Specify packs/day_____)

Use of Drugs: ☐Never ☐Previously, but quit ☐Rarely ☐Moderate ☐Daily

Exercise: ☐Never ☐Rarely ☐Daily

Excessive Exposure to: ☐Fumes ☐Dust ☐Air-borne Particles ☐Noise ☐Asbestos

FAMILY MEDICAL HISTORY:

	AGE	DISEASES	IF DECEASED, CAUSE OF DEATH
Father:			
Mother:			
Siblings:			
Children:			

PREVIOUS HOSPITALIZATIONS/ SURGERIES/SERIOUS INJURIES: (INCLUDE DATE)

MEDICATIONS & HOW THEY ARE TAKEN:

PREVIOUS IMMUNIZATIONS:

ALLERGIES:

None recorded.

PATIENT MEDICAL HISTORY **SYSTEM REVIEW**

ALLERGIC/IMMUNOLOGIC:

History of skin reaction or other reaction to:

Penicillin or other antibiotics	☐No	☐Yes
Morphine, Demerol, or other narcotics	☐No	☐Yes
Novocain or other anesthetics	☐No	☐Yes
Aspirin or other pain remedies	☐No	☐Yes
Tetanus antitoxin or other serums	☐No	☐Yes
Iodine, methiolate or other antiseptics	☐No	☐Yes

CONSTITUTIONAL SYMTPOMS:

Good general health lately	☐No	☐Yes
Recent weight change	☐No	☐Yes
Fever	☐No	☐Yes
Fatigue	☐No	☐Yes
Headaches	☐No	☐Yes

EYES:

Date of last eye exam: _____

Eye disease or injury	☐No	☐Yes
Wear glasses/ contact lens	☐No	☐Yes
Blurred or double vision	☐No	☐Yes
Glaucoma	☐No	☐Yes
Cataracts	☐No	☐Yes

EARS/ NOSE/ MOUTH/ THROAT:

Hearing loss or ringing	☐No	☐Yes
Earaches or drainage	☐No	☐Yes
Chronic sinus problem or rhinitis	☐No	☐Yes
Nose bleeds	☐No	☐Yes
Mouth sores	☐No	☐Yes
Bleeding gums	☐No	☐Yes
Bad breath or bad taste	☐No	☐Yes
Sore throat or voice change	☐No	☐Yes
Swollen glands in neck	☐No	☐Yes

CARDIOVASCULAR:

High blood pressure	☐No	☐Yes
Chest pain or angina pectoris	☐No	☐Yes
Palpitations	☐No	☐Yes
Shortness of breath with walking or lying flat	☐No	☐Yes
Swelling of feet, ankles or hands	☐No	☐Yes

RESPIRATORY:

Chronic or frequent coughs	☐No	☐Yes
Spitting up blood	☐No	☐Yes
Shortness of breath	☐No	☐Yes
Asthma or wheezing	☐No	☐Yes

GASTROINTESTINAL:

Loss of appetite	☐No	☐Yes
Change in bowel movements	☐No	☐Yes
Nausea or vomiting	☐No	☐Yes
Frequent diarrhea	☐No	☐Yes
Painful bowel movements or constipation	☐No	☐Yes
Rectal bleeding or blood in stool	☐No	☐Yes
Abdominal pain or heartburn	☐No	☐Yes
Peptic ulcer [stomach or duodenal	☐No	☐Yes
Have you ever had a colonoscopy	☐No	☐Yes

If yes, date of last: _____

PSYCHIATRIC:

Memory loss or confusion	☐No	☐Yes
Nervousness	☐No	☐Yes
Depression	☐No	☐Yes
Insomnia	☐No	☐Yes

GENITOURINARY

Frequent urination	☐No	☐Yes
Burning or painful urination	☐No	☐Yes
Blood in urine	☐No	☐Yes
Change of force of strain when urinating	☐No	☐Yes
Incontinence or dribbling	☐No	☐Yes
Kidney stones	☐No	☐Yes
Sexual difficulty	☐No	☐Yes

For Males:

Testicle pain	☐No	☐Yes

For Females:

Pain with periods	☐No	☐Yes
Irregular periods	☐No	☐Yes
Vaginal discharge	☐No	☐Yes

# of Pregnancies___ #of Miscarriages___#of Abortions____

Age of 1st period____

Date of last pap smear_____

Date of last mammogram_____

MUSCULOSKELETAL:

Joint pain	☐No	☐Yes
Joint stiffness or swelling	☐No	☐Yes
Weakness of muscle or joints	☐No	☐Yes
Muscle pain or cramps	☐No	☐Yes
Back pain	☐No	☐Yes
Cold extremities	☐No	☐Yes
Difficulty in walking	☐No	☐Yes

INTEGUMENTARY [skin, breast]:

RASH or itching	☐No	☐Yes
Change in skin color	☐No	☐Yes
Change in hair or nails	☐No	☐Yes
Varicose veins	☐No	☐Yes
Breast pain	☐No	☐Yes
Breast lump	☐No	☐Yes
Breast discharge	☐No	☐Yes

NEUROLOGICAL:

Frequent or recurring headaches	☐No	☐Yes
Light headed or dizzy	☐No	☐Yes
Convulsions or seizures	☐No	☐Yes
Numbness or tingling sensations	☐No	☐Yes
Tremors	☐No	☐Yes
Paralysis	☐No	☐Yes
Stroke	☐No	☐Yes
Head injury	☐No	☐Yes

ENDOCRINE:

Glandular or hormonal problem	☐No	☐Yes
Thyroid disease	☐No	☐Yes
Diabetes	☐No	☐Yes
Excessive thirst or urination	☐No	☐Yes
Heat or cold intolerance	☐No	☐Yes
Skin becoming dryer	☐No	☐Yes

HEMATOLOGIC/ LYMPHATIC:

Slow to heal after cuts	☐No	☐Yes
Bleeding or brusing tendency	☐No	☐Yes
Anemia	☐No	☐Yes
Phlebitis	☐No	☐Yes
Past blood transfusions	☐No	☐Yes
Enlarged glands	☐No	☐Yes

Macon Volunteer Clinic
Patient Appointment Agreement

In the event that you cannot make your appointment at Macon Volunteer Clinic (MVC), please provide 48 hours' notice to cancel or reschedule your appointment. Your courtesy will allow us to see another patient during that appointment time.

If you do not cancel your appointment, within these guidelines, you will be considered a "no-show", Three clinic "no-shows" will result in your being discharged from MVC for one year.

One "no-show" for an appointment with an offsite specialty healthcare provider will result in your being discharged from MVC for one year.

I understand that one "no show" for an appointment with an offsite specialty healthcare provider will result in my being discharged from MVC for one year.

_____
Initials

I understand that I must provide 48 hours' notice when canceling or rescheduling an appointmentat the clinic to prevent being a "no-show". Three clinic no-shows will result in my being discharged from MVC for one year.

_____
Initials

The first time I "no-show" for an appointment, I will receive a letter reminding me of my responsibility to call to cancel or reschedule my appointment with 48 hours notice. I understand I will receive a letter if there is a second "no-show".

_____
Initials

If I have a third "no-show", I understand that I will receive a letter of discharge. I understand that I will not be eligible to receive services at Macon Volunteer Clinic for one year.

_____
Initials

On occasion, my healthcare provider will request that I go for labs, x-rays, or other diagnostic services at another facility.These services are free. I will follow the instructions given by my healthcare provider and/or MVC staff before I go for my tests.If I receive a bill for services requested by MVC, I will bring the bill to the clinic immediately.

_____
Initials

I understand that I may be referred to the emergency room for acute care. All emergency room chargers are my responsibility.

_____
Initials

I have been given a copy of the Patient Appointment Agreement for my records.

_____
Initials

MVC does not tolerate rude, inconsiderate, or aggressive behavior. I understand that if I am rude, inconsiderate, or aggressive, I may be dismissed from MVC as a patient for 12 months.

I, _____, understand MVC's Patient Visit Agreement.

_____ _____ Date

Patient Appointment Agreement for Signature rev May 2022

Patient Agreement

I understand that Macon Volunteer Clinic physicians will serve as my primary care physicians. I will not see any other physicians unless first referred by MVC physicians.

_____ Initials

I understand that I must screen for eligibility every year to remain a patient at MVC. Each year, the deadline for submitting all required information will be April 30.

_____ Initials

I understand that if I need medical care outside of clinic hours for an urgent medical problem, I should go to an Urgent Care facility. In the case of a true medical emergency, I should go to the nearest Emergency Room or call 911. *There are no MVC doctors on call on nights, weekends, or holidays.* Expenses for services provided at any facility other than Macon Volunteer Clinic are my responsibility.

_____ Initials

I understand that if I need a work excuse, I will notify the receptionist when I check in for my appointment.

_____ Initials

I understand that I must comply with regular lab work or other test as ordered. Failure to obtain labs as required may result in discharge. You must be current on lab work before being seen for dental, eye, or other speciality appointments.

_____ Initials

I understand that I must bring my medications to every doctor visit.

_____ Initials

I understand that if I have diabetes, I must bring my glucometer to every doctor visit.

_____ Initials

I understand prescription renewal requests can only be made during doctor visits. I understand it is my responsibility to know when my refills are due!

_____ Initials

I understand that if I require a refill of my medication(s) from a pharmacy, I must notify MVC at***least 48 hours*** before I run out of medication(s).

_____ Initials

I understand that if I require a refill of PPAP medication(s), I must notify the Patient Assistance Coordinator at***least two weeks*** before I run out of your medication(s).

_____ Initials

I understand that I am required to give 48 hours' notice when I cancel an appointment.

_____ Initials

Due to space limitations, I understand that only the patient is allowed in the exam room during physical exam,

_____ Initials

I understand that no children are allowed at clinic visits.

_____ Initials

I understand that I must notify MVC if I have a phone or address change.

_____ Initials

I have been given a copy of the Patient Agreement for my records.

_____ Initials

Patient Agreement rev May 2022

DPH

Georgia Department of Public Health
Georgia Volunteer Health Care Program (GVHCP)
Patient Financial Eligibility Form

Georgia Volunteer
Health Care Program

Clinic/Program/Provider: Macon Volunteer Clinic

SECTION I - PATIENT DEMOGRAPHIC INFORMATION

Patient Name:

_____
(Last Name) (First Name) (Middle Initial) (Nickname or Preferred Name)

Address:

_____
(Street) (City/State) (Zip Code) (County)

Telephone number: _____ **Secondary Telephone number:** _____

Date of Birth _____ **Sex:** _____ **Race/Ethnicity:** _____

SECTION II - INSURANCE INFORMATION/FINANCIAL ELIGIBILITY

Do you have insurance that covers? ☐ Health ☐ Vision ☐ Dental ☐ No Insurance

If you have insurance, what services/specialty does your insurance exclude?_____.

Do you currently have Georgia Medicaid? ☐ Yes ☐ No **Medicare Part B?** ☐ Yes ☐ No

I am: Uninsured (no insurance) Underinsured (do not have coverage for services being sought)

Your income must be at or below 200% of the Federal Poverty Level to be eligible to receive services under the GVHCP.

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

Please provide gross family monthly income from all sources: $_____.

SECTION III - LEGAL ACKNOWLEDGEMENTS

I understand that I am being referred to a volunteer health care provider who will provide care to me or to someone for whom I am legally responsible. My participation in this referral process is voluntary. The care I receive from the volunteer health care professional will be provided at no charge. I understand that the Volunteer is acting as an employee of the State of Georgia by treating me pursuant to the "Georgia Volunteer Health Care Program." I acknowledge that the exclusive remedy for any injury or damage suffered as a result of any act or omission of a health care provider acting within the scope of duties pursuant to that Program is a lawsuit under the State Tort Claims Act, O.C.G.A. § 50-21-20 et seq.

The information I have provided regarding my eligibility, including income information, is true and complete to the best of my knowledge. I understand that any failure to update this information to the Department upon change in my financial or health insurance status may disqualify me from receiving health or dental care under the GVHCP. I further understand that making false statements or representations on this form may be punishable under O.C.G.A. Section 16-10-20 by a fine of not more than $1,000 or by imprisonment for not less than one or more than five years, or both.

Signature of Patient/Parent or Guardian	**Printed Name of Person Signing**	**Relationship to Minor**
Signature of Eligibility Specialist	**Printed Name of Eligibility Specialist**	**Date**

Macon Volunteer Clinic

Patient Confidentiality Release Documents

I, _____, give permission for the following persons to have acess to my medical records, to include test results, appointment information, information regarding my care and other types of records to include billing and insurance information.

Name	Relationship to Patient	Phone Number

Macon Volunteer Clinic has my permission to leave *Confidential phone messages* at the following number(s):

My home Phone number:

My cell phone number:

My work phone number:

Or Macon Volunteer Clinic does not have my permission to leave confidential phone messages.

_____
Initials

This release is valid unless revoked in writing.

Signed:_____ Date:

NOTICE OF PRIVACY PRACTICES

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.

Federal law requires the Macon Volunteer Clinic (MVC) to:

- Maintain the privacy of your protected health information;
- Provide you with this Notice of Privacy Practices;
- Abide by the terms of this Notice; and
- Change the Notice only as it states it will do.

Under Federal Privacy Regulations you have the following rights:

- Right to request restrictions on certain uses and disclosures, though MVC is not required to agree to such restrictions. If MVC is willing to accept such restrictions, additional statements concerning its duty to honor such restrictions and the process for terminating the restrictions will be provided.
- Right to receive confidential communications from MVC;
- Right to inspect and copy your own Protected Health Information;
- Right to receive an accounting of disclosures of Protected Health Information;
- Right to consent to uses and disclosures of your Protected Health Information for treatment, payment, and operations.
- Right to review this Notice of Privacy Practices before signing any consent.
- Right to authorize uses and disclosures of information for all other purposes, subject to the exceptions created by the HIPAA Privacy Standards.
- Right to appeal denials of access to your own information to MVC except in certain circumstances.
- Right to amend incorrect or incomplete information. If the amendment is denied, you have a derivative right to protest the refusal to amend, as well as to require the protest to be attached to all future disclosures of the information.
- Right to file a complaint with MVC if it fails to follow the requirements of the privacy Standards.
- Right to opt-out of disclosure of information to facility directories (including disclosure to clergy) or to family members or others who may be assisting with care.
- Right to file a complaint with the Secretary of the Department of Health and Human Services if you believe privacy rights have been violated You should direct the complaint to:

Office of Civil Rights; Attn: Privacy
U.S. Department of Health and Human Services
200 Independence Avenue Room 509F
Washington, D.C. 20201
e-mail address:ocrprivacy@hhs.gov

- Right to receive a paper copy of this Notice.

MVC conducts a program in cooperation with certain health care and other entities including; Medical Center of Central Georgia; Bibb County Health Department; W.T. Anderson Clinic; or Women's Health Services; River Edge Behavioral Health Center and Department of Family and Children's Services of Bibb County; Social Security Office for Bibb, County; Mercer University; Macon State College. and Georgia State University as well as participating physicians. MVC's purpose is to provide health care to the working uninsured who meet the eligibility requirements of the clinic. In order to perform this function, it is necessary for MVC to disclose personal, financial, medical, and utilization information along with other Protected Health Information to the above and other entities.

MVC may use your Protected Health Information for or incident to your treatment in the health operations of MVC. Treatment may include primary care for acute and chronic diseases, the ordering of laboratory and for radiological studies, or subsequent referral to a specialist for specialty care, and in some cases these uses will require MVC or its affiliates to share information obtained rendering services to you with one or more of its affiliates.In order to establish eligibility, MVC will ask for documentation of payment information which includes financial and household income information, sources of payment, payment plan arrangements and the like and will be transmitted or shared incident to your treatment an referral. MVC does not charge for health care services. Business operations include information about diagnosis, treatment, payment and certain other activities, such as utilization quality assurance review. MVC might also share your personal health information incident to its tracking of certain physical conditions and illnesses. Further information on your rights pursuant to this Notice of Privacy Practices can be found at 42 CFR § 164.520 "Notice of Privacy Practices for Protected Health Information".

- For more information or to file an internal complaint, contactthe NSA director at (205) 327-8254.
- This NPP may be amended by action of the Board of Directors of MVC in its discretion as it determines necessary.

Signature of Recipient

Date of Execution

Printed Name of Recipient

Macon Volunteer Clinic
Healthcare with Heart

Late Appointment Policy

Macon Volunteer Clinic recognizes that occasionally, circumstances outside our control cause us to be late for appointments. We strive to understand and be flexible, while being considerate of the volunteer doctors and nurses that donate their time to our Clinic.

If you arrive 15 minutes late or more to your appointment at Macon Volunteer Clinic, you may be asked to reschedule, unless our schedule can still accommodate you. Priority will be given to the patients who arrive on time, and you may have to be worked in between them.

Please remember: Your late arrival has negative consequences to the care provided, to other patients being seen on time, and to our clinic volunteers and staff. Please be considerate by allowing extra travel time and arriving early!

*_____

DATE: _____