NORTH MACON FAMILY HEALTHCARE

PATIENT INFORMATION		
Last Name:	First Name:	Middle Initial:
Date of birth:	SSN:	Phone:
Address:		
City:	State:	Zip Code:
Single Married Widowed Divorced (Please circle)		
Email:	Male or Female (Please circle)	Pharmacy:
SPOUSE INFORMATION		
Name:	SSN:	Date of birth:
Employer:		
Work Address:		Work Phone:
MUST COMPLETE IF UNDER 18		
Father/Legal Guardian Name:		
Date of birth:	SSN:	Phone:
Mother/Legal Guardian Name:		
Date of birth:	SSN:	Phone:
EMPLOYMENT INFORMATION		
Current employer:		
Employer address:		Phone:

AUTHORIZATIONS

- I hereby authorize and request the medical treatment necessary for the care of the above named patient.
- If you No-Show for your scheduled appointment, a $25.00 fee will be charged.
- I acknowledge full financial responsibility for services rendered by North Macon Family Healthcare Associates, LLC. I understand payment is due at the time of services rendered unless other definite financial arrangements have been made prior to treatment. I understand that I am responsible for any un-met deductibles and co-insurance fees.
- I understand that insurance companies have agreements with certain laboratories for lab work and that it is my responsibility to know which laboratory my insurance authorizes and to inform staff as to which laboratory my insurance covers.
- I further authorize and request that insurance payments be made directly to North Macon Family Healthcare Associates, LLC, for services rendered.

I have read and fully understand the above consent for treatment, release of information, financial responsibility and insurance authorization.

X ______________________________
Patient/ Parent or Guardian (Please Print)

X ______________________________
Patient/ Parent or Guardian Signature

NORTH MACON FAMILY HEALTHCARE

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to anyone except when you have authorized us to do so.

PATIENT MEDICAL HISTORY

Name:	DOB:	Date:

Please list the dates and diagnosis of any and all surgeries:

ILLNESS

Have you ever had: (Please circle)

High blood pressure	YES OR NO	Kidney Disease	YES OR NO
Heart Attack	YES OR NO	Diabetes	YES OR NO
Heart Failure	YES OR NO	Thyroid Disease	YES OR NO
High cholesterol	YES OR NO	Cancer	YES OR NO
Stroke	YES OR NO	Migraine Headaches	YES OR NO
Asthma, Emphysema	YES OR NO	Syphilis or Gonorrhea	YES OR NO
Ulcers	YES OR NO	Herpes, Other STD	YES OR NO
Hepatitis	YES OR NO	Other:	

ALLERGIES

Are you allergic to: (Please circle)

Penicillin: YES or NO	Sulfa: YES OR NO	Other Drugs:______________________

Any foods:

IMMUNIZATIONS

Have you had any of the following immunizations:

Tetanus: YES OR NO	Pneumococcal YES OR NO
Hepatitis YES OR NO	Influenza YES OR NO

SOCIAL HISTORY

Do you drink alcohol? YES OR NO How much? ________________________

Tobacco use? YES OR NO How often? ____________________________________

Do you use electronic cigarettes? YES OR NO Other Drugs? YES OR NO

NORTH MACON FAMILY HEALTHCARE

FAMILY MEDICAL HISTORY		
Age of Father:	**If Deceased** Age at Death: Cause:	Condition present in any blood relative: (Please circle)
Age of Mother:		Cancer Y OR N
Age of Siblings: 1.		Tuberculosis Y OR N
2.		Diabetes Y OR N
3.		Stroke Y OR N
Age of Spouse:		Seizures Y OR N
Age of Child(ren):		Liver Disease Y OR N
2.		Kidney Disease Y OR N
3.		Asthma Y OR N
4.		Heart Problems Y OR N
5.		Arthritis Y OR N
How many siblings do you have? _________ How many children do you have? _________		

CURRENT MEDICATIONS		
NAME OF DRUG:	DOSAGE:	HOW OFTEN PER DAY:

WOMEN ONLY- MENSTRUAL HISTORY		
Age at onset:	Date of last period:	Last mammogram:
Are your cycles regular? YES OR NO	Do you take birth control pills? YES OR NO	
Date of last pap smear:	Results: POSITIVE OR NEGATIVE	
Pregnancies: How many children born alive? ________	How many still births? _________	
How many premature births? _________	How many caesarean births? _____________	
How many miscarriages? ___________	Any other complications with pregnancies?	

PATIENT ACKOWLEDGEMENT FORM

Patient Acknowledgement of Understanding of North Macon Family Healthcare Associates Privacy Practices
Patient's name:________________________________Date of Birth:_______________
SSN: ___________________________

I understand that the patient's health information is private and confidential. I understand that North Macon Family Healthcare Associates works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand the North Macon Family Healthcare Associates may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One more example would be if a patient threatened to hurt someone.

North Macon Family Healthcare Associates has a detailed document call the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy and is available to me upon request. I understand that I have the right to read the "Notice of Privacy Practices" before signing this Acknowledgement.

North Macon Family Healthcare Associates may update this Acknowledgement and "Notice of Privacy Practices". If I ask, North Macon Family Healthcare Associates will provide me with the most current "Notice of Privacy Practices".

Within this "Notice of Privacy Practices" is contained a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to access to my medical records; restrictions on certain uses; receiving and accounting of disclosures as required by law; and requesting communication is by specified methods of communications or alternative location.

North Macon Family Healthcare Associates has established procedures which help them meet their obligations to patients. These procedures may include signature requirements, written acknowledgements, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist North Macon Family Healthcare Associates by following these procedures if I choose to exercise any of my rights described in the "Notice or Privacy Practices".

My signature below indicates that I have been given the chance to review a current copy of the North Macon Family Healthcare Associates "Notice of Privacy Practices".

X ______________________________ X ______________________________
Patient Signature Date

Patient Health Information Release Form
North Macon Family Healthcare Associates

1) I authorize North Macon Family Healthcare Associates to release my protected health information to my insurance company for purposes of billing, collections, and prior authorization for services provided by the office.

Signature____Date:___________

2) I authorize North Macon Family Healthcare Associates to release my protected health information to other physicians, healthcare providers, or technicians for the purpose of continuing medical treatment, discussion, or consultation.

Signature____Date:_____________

3) I authorize North Macon Family Healthcare Associates to communicate with any and all pharmacies, and hereby authorize said pharmacy to release information regarding my current and past pharmaceutical treatments, including drug, strength, amount, date, refills and prescriber.

Signature____Date:_______________

4) I authorize North Macon Family Healthcare Associates to leave messages at my home and/or workplace, and/or send mail regarding appointments; need to contact the office, or other matters not involving specific medical information.

Signature____Date:_______________

5) I authorize North Macon Family Healthcare Associates to discuss my medical condition with the following family members:

Sign Here if NONE:____Date:________________

Sign Here if YES:____Date:________________

If yes, list the names, phone number, and relationship of those with whom we may discuss your care:

<u>North Macon Family Healthcare</u>

<u>Assignment of Benefits</u>

Patient Name ______________________ Date____________________

Insurance________________________________ Member ID#___________________

I,_____________________________________ (**Patient's name**) understand that services rendered to me by North Macon Family Healthcare are my financial responsibility and that the office will bill my insurance company__________________________________ (**Insurance Name**) as a courtesy. I authorize my insurance company to pay my benefits directly to North Macon Family Healthcare and I understand that I will be fully responsible for any outstanding balance on this account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by__________________________________ (**Insurance Name**).

I also understand that should my insurance company send payments to me, I will forward the payment to North Macon Family Healthcare within 48 hours. I agree that if I fail to send the payment to the provider and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event patient receives any check, draft, or other payment subject to this agreement, I will immediately deliver said check, draft or payment to provider. Any violations of this agreement will, at provider's election, terminate patient charge privileges with provider and bring any balance owed by patient to provider immediately due and payable.

I authorize the provider to initiate a complaint or file an appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions of denials.

X ______________________________
Signature of Patient or Legal Guardian

X ______________________________
Signature of Witness