North Macon Family Health Care Associates, LLC

REGISTRATION FORM

PATIENT INFORMATION

Last Name:_____ First Name:_____MI:_____Preferred Name:_____

SS#:_____ ____ Single ____ Married ____Widowed ____Divorced

Date of Birth_____ Age:_____ M / F Employer: _____

Address:_____ Work Addr:_____

City:_____ST:_____Zip:_____ Primary Insurance:_____

Email:_____ Subscriber: _____DOB:_____

Home Phone:_(_____)_____ Secondary Insurance:_____

Work Phone:_(_____)_____ Subscriber: _____DOB:_____

Cell Phone:_(_____)_____ Method of contact for appointment reminders: Call Text Email

SPOUSE INFORMATION

Name:_____ Work Phone:_(_____)_____

SS # :_____ Employer:_____

Date of Birth:_____ Work Addr:_____

MUST COMPLETE IF UNDER 18

Father

Name:_____

Address:_____

SS # :_____

Date of Birth:_____

Work Phone:_(_____)_____

Employer:_____

Mother

Name:_____

Address:_____

SS # :_____

Date of Birth:_____

Work Phone:_(_____)_____

Employer:_____

AUTHORIZATIONS

************PLEASE PRESENT INSURANCE CARDS TO THE RECEPTIONIST************

- 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 charged.
- I acknowledge full financial responsibility for services rendered by **North Macon Family Health Care Associates, LLC**. I understand payment is due at the time of service 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 the staff of **North Macon Family Health Care Associates, LLC** as to which laboratory my insurance covers.
- I further authorize and request that insurance payments be made directly to **North Macon Family Health Care Associates, LLC**, for services rendered.

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

_____ _____ _____

Patient / Parent or Guardian (Please Print) Patient / Parent or Guardian Signature Date

PATIENT MEDICAL HISTORY

NAME _____ DOB _____ DATE _____ Chart # _____

Please check the correct box below:

SURGERIES

List dates & diagnosis:

_____
_____
_____
_____
_____

	No	Yes
Have you ever been advised to have surgery which was not done?	☐	☐
Have you ever had a blood or plasma transfusion?	☐	☐

HOSPITALIZATIONS

List dates and diagnosis:

_____
_____
_____
_____
_____

ILLNESS

Have you ever had:	No	Yes
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Heart Failure	☐	☐
Stroke	☐	☐
Asthma, Emphysema	☐	☐
Other Lung Disease	☐	☐
Ulcers	☐	☐
Hepatitis	☐	☐
Kidney Disease	☐	☐
Diabetes	☐	☐
Thyroid Disease	☐	☐
Cancer	☐	☐
Migraine Headache	☐	☐
Syphilis, Gonorrhea	☐	☐
Herpes, Other STD	☐	☐

Other _____
_____
_____

INJURIES

Have you ever had:	No	Yes
Broken Bones	☐	☐
Dislocations	☐	☐
Head Injury	☐	☐
Loss of Consciousness	☐	☐

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.

ALLERGIES

Are you allergic to:	No	Yes
Penicíln	☐	☐
Sulfa	☐	☐

Other Drugs: _____
_____

Any Foods: _____
_____

Other: _____
_____

IMMUNIZATIONS

	No	Yes
Tetanus	☐	☐
Hepatitis	☐	☐
Pneumococcal	☐	☐
Influenza	☐	☐

Other: _____
_____
_____

SOCIAL HISTORY

Employed As:	No	Yes
Alcohol Use	☐	☐
How Much _____		
Tobacco Use	☐	☐
How Much _____		
Other Drugs	☐	☐
How Much _____		
Any Pets	☐	☐
What Kind _____		

Hobbies _____
_____

Any travel outside the USA?	☐	☐
Where _____		

_____

Do you have well water?	☐	☐

How many people live in your home?_____

FAMILY MEDICAL HISTORY

	If Living		If Deceased		Please Circle		
	Age	Health	Age at Death	Cause	Condition Present In Any Blood Relative:		Relation
FATHER					CANCER	YES or NO	
MOTHER					TUBERCULOSIS	YES or NO	
SIBLINGS 1					DIABETES	YES or NO	
2					HEART TROUBLE	YES or NO	
3					STROKE	YES or NO	
4					EPILEPSY	YES or NO	
5					LIVER DISEASE	YES or NO	
SPOUSE					KIDNEY DISEASE	YES or NO	
CHILDREN 1					ARTHRITIS	YES or NO	
2					ASTHMA	YES or NO	
3					BLOOD DISORDER	YES or NO	
4					OTHER CONDITION	YES or NO	

Other Details: _____

PRESENT MEDICATIONS

Please indicate all prescription and non-prescription drugs that you currently take.

NAME OF DRUG	DOSAGE	HOW OFTEN PER DAY

WOMEN ONLY – MENSTRUAL HISTORY

Age at Onset _____

Cycles Regular? Yes ☐ No ☐

_____ Days (From Start to Start)

Flow Heavy ☐ Medium ☐ Light ☐

Clots Passed? Yes ☐ No ☐

Pain or Cramps? Yes ☐ No ☐

DATE OF LAST PERIOD _____

DATE OF LAST PELVIC EXAM _____

DATE OF LAST PAP SMEAR _____

RESULTS: Positive ☐ Negative ☐

DATE OF LAST MAMMOGRAM

_____ Yes ☐ No ☐

Discharge or Itching From Vagina?

If Yes, What Color? _____

Do You Take Birth Control Pills? Yes ☐ No ☐

How Long Have You Taken Them? _____

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 ACKNOWLEDGEMENT 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 be 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".

_____

Date

_____

Relationship to patient if signed by any one other than the patient (parent, legal guardian, personal representative, etc)

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.

Initial:_____ 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.

Initial:_____ 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.

Initial:_____ 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.

Initial:_____ 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 name and relationship of those with whom we may discuss your care. Also, list who we should contact in case of an emergency (I.C.E.) and their phone number:

_____ _____

_____ _____

_____ _____

CENTRAL GEORGIA HEALTH EXCHANGE

The next generation of patient information

Permission to Create a *Health Exchange record* and Share My Medical Information with my Healthcare Providers

We are taking part in an exciting program to improve your healthcare and make office visits easier and more convenient. To do this, all of your doctors participating in the Central Georgia Health Network (CGHN) would like your permission to share your Health Information (as defined below) through the *Central Georgia Health Exchange* electronic medical record program (*Health Exchange*). This will authorize your CGHN-participating doctors to disclose your Health Information so that it can be shared electronically with other providers of healthcare to you.

I acknowledge that I have read the information set forth below and understand the permission I am giving in this document, and have had the opportunity to have my questions answered about the *Health Exchange and this* permission form.

☐ Yes, I agree to participate in the Central Georgia Health Exchange electronic medical record

☐ No, I do not agree to participate in the Central Georgia Health Exchange electronic medical record

Printed Name of Patient/Representative	*Signature of Patient/Representative*	*Date*

AUTHORITY OF REPRESENTATIVE:

I, _____, do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis (Relationship to Patient): _____

[A signed copy of this permission will be provided to the patient/representative]

This authorization will allow your CGHN-participating doctors to disclose your demographic, insurance, and medical information so that it can be shared with other providers of healthcare to you (including doctors, nurses, and other health professionals, as well as hospitals and other healthcare facilities) and CGHN, through the *Health Exchange* electronic medical record system. Only authorized healthcare providers and their contractors, and others whose job it is to maintain, secure, monitor and evaluate the operation of the information system and quality of care, would be able to access your information. The *Health Exchange* will allow your providers access to your health information more quickly and accurately than with paper charts.

By signing this authorization, I authorize all of my doctors who participate in CGHN to use and disclose my Health Information and to make such Health Information available through the *Health Exchange* to other healthcare providers who need access to my Health Information for the purposes described in this document. The Health Information may include, but is not limited to the following: Information contained in medical records; physicians' records; surgeons' records; x-rays, CAT scans, MRI films, photographs, or other radiological, nuclear medicine or radiation therapy films; pathology materials, slides or tissues; laboratory reports; genetic testing results; discharge summaries; progress notes; consultations; prescriptions; records of child abuse, spousal abuse, drug abuse and alcohol abuse; HIV/AIDS and sexually transmitted diseases diagnosis or treatment; physicals and histories; nurses' notes; patient intake forms; correspondence; social workers' records; insurance records; consents for treatment; and any other documents concerning any treatment, examination, periods of hospitalization, confinement, diagnosis or other information concerning my physical or mental condition.

Information disclosed pursuant to this permission may no longer be protected by federal health information privacy laws and may be subject to redisclosure. However, the *Health Exchange* system incorporates access controls, encryption technology and other security features designed to protect the privacy and security of your Health Information. In addition, access to the *Health Exchange* will be limited to only those users who have agreed to use the *Health Exchange* consistent with your permission. Information shared through the *Health Exchange* will be used and disclosed for the following purposes and disclosures: clinical care; obtaining reimbursement for health care services; ; for administrative functions related to the provision of and payment for care; quality monitoring and improvement; and administrative management of the *Health Exchange* and CGHN.

You can learn more about the *Central Georgia Health Exchange* by reading the information booklet, "A Guide To The Central Georgia Health Exchange" that is available at the CGHE website (https://www.CGHE.net) or on request from your doctor's office.

I understand that I may withdraw this permission by giving written notice to Administrator, Central Georgia Heath Exchange, 777 Hemlock Street, Hospital Box 98, Macon, GA 31201. Any withdrawal of permission will be effective except to the extent action already has been taken in reliance on this permission. This permission will expire automatically if the *Central Georgia Health Exchange* program is discontinued.

I understand that my eligibility for treatment or any healthcare benefits cannot be conditioned on whether I sign this permission. However, to the extent I have refused permission, I understand that my Health Information will not be available to other providers (including The Medical Center of Central Georgia) through the *Central Georgia Health Exchange*.

North Macon Family Healthcare

Assignment of Benefits

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 my 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 payment 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 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 or denials.

_____ _____

Signature of **Patient or Legal Guardian** Signature of **Witness**