

MEADOWS MEDICAL GROUP REGISTRATION FORM

(Please Print)



PODIATRY

Today's date		
PATIENT DEMOGRAPHIC INFORMATION		
Last Name		Employer Name
First Name		Employer Address
Middle Name		Employer City
Birthdate _____ / _____ / _____ MM / DD / YYYY		Employer State ZIP Code
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other		Employer Phone
Social Security Number		Occupation Employment Status <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Unemployed
Address		Language
City	Zip Code	Marital Status
State		Race
Email Address or N/A <input type="checkbox"/>		Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown
Home Phone		Cell Phone
Work Phone		Primary Care Provider

PATIENT DEMOGRAPHIC INFORMATION (FOR MINORS ONLY)			
MOTHER'S INFORMATION		FATHER'S INFORMATION	
Name		Name	
DOB	Social Security Number	DOB	Social Security Number
Address		Address	
City, State, Zip		City, State, Zip	
Home Phone Number		Home Phone Number	
Cell Phone Number		Cell Phone Number	
Employer Name		Employer Name	
Work Phone Number		Work Phone Number	

INSURANCE INFORMATION		
Primary Insurance		
Name of Insurance Holder (Last, First, Middle)		
Relation to Patient		
Birthdate	Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address		
City	State	Zip
Insurance Holder Phone Number	Phone Type	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
Policy Number	Group Name	
Group Number		
EMERGENCY CONTACT INFORMATION		
Name (Last, First, Middle)		
Relation to Patient	Phone	Type <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
Address		
City	State	Zip
GUARANTOR INFORMATION SKIP IF SAME AS PATIENT		
Name (Last, First, Middle)		
Relation to Patient	Social Security Number	
Address Line 1		
City	State	Zip
Home Phone	Cell Phone	
Employer Name	Employer Address	
Employer City	Employer State	Employer Zip Code
Employer Phone	Employer Fax	
Employment Status <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Unemployed		

COMMUNICATION PREFERENCES REGARDING:						
	Appointment		Clinical		Financial	
Method (Check for All: <input type="checkbox"/>)	May Call	May Leave Messages	May Call	May Leave Messages	May Call	May Leave Messages
Cell Phone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Home Phone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work Phone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ACKNOWLEDGMENT OF RECEIPT OF HIPAA NOTIFICATION FORM

Signature below is acknowledgement that have been given and had the opportunity to read our **Notice of Privacy Practices**. Should you wish to read the Notice at any other time, please request upon the arrival of your office visit. Any questions concerning our policy should be directed to our staff for clarification. It is our policy to provide this Notice at your first visit, and you may obtain another copy at any subsequent visit. This acknowledgment and authorization remains in effect until we are notified, in writing, by you of any changes.

Please list all additional authorized persons with whom we may discuss any of your medical information (including scheduled appointments):

Name	Relationship to Patient	Phone Number
Name	Relationship to Patient	Phone Number
Name	Relationship to Patient	Phone Number
Name	Relationship to Patient	Phone Number
Name	Relationship to Patient	Phone Number
Name	Relationship to Patient	Phone Number

Patient Name	Patient's DOB
Signature	Today's Date

**NEW PATIENT REGISTRATION – ACKNOWLEDGEMENT AND DISCLOSURES
STANDARD FORM FOR ALL ENTITIES ASSOCIATED WITH SOUTHEAST REGIONAL PRIMARY
CARE CORPORATION AND/OR MEADOWS REGIONAL MEDICAL CENTER, INC. OF WHICH
THIS CENTER IS ASSOCIATED**

PHYSICIAN PRACTICES POLICY AND RELEASE OF INFORMATION

The following is a statement of our Financial Policy for services provided within our office and does not apply to any testing or diagnostic procedure performed outside of the physician practice. We require you to read and sign this document prior to treatment by this facility.

PATIENT RESPONSIBILITY

All professional services rendered are charged to the patient and are due at the time of service. As a courtesy, this practice will file your claim with your insurance carrier; however, the patient or responsible party is ultimately responsible for the charges not covered by your contract with the carrier. **Any co-payments or deductible amounts not satisfied with your carrier are due at the time of service.**

Initial: _____

Insurance carriers typically do not cover all medical costs. Some pay fixed allowances for each procedure and office visit while others pay only a percentage of the costs. Surgical procedures, labs and other outpatient procedures may have a higher co-payment or fall under the deductible. It is the patient's responsibility to understand their insurance coverage.

Initial: _____

When you receive a statement, you are required to pay the balance upon receipt of the statement. If for some reason you do not agree with the balance due amount, you must contact a billing representative at the phone number noted on the statement. Do not ignore the bill, as it may result in turning the balance to an outside collection agency for recovery.

Initial: _____

AUTHORIZATION FOR TREATMENT AND TO RELEASE INFORMATION

The signature below serves as authorization for medical treatment by the physician, physician's assistant, nurse practitioner, or nurse for the named patient. It also provides authorization for our office to furnish and/or release any information necessary to insurance carriers, third party administrators, self-insured plan administrator and/or other health benefit payor or representatives in order to process health care claims incurred at this office or for utilization review or quality assurance. This authorization serves as permission to obtain a copy of your complete medical record for or from other physician practices or medical facilities. A copy of this authorization may be used in place of the original in obtaining the medical records. I understand that I may withdraw this authorization to release medical information at any time, by communicating to the practice either in writing or verbally, followed by a written withdrawal.

Initial: _____

I understand that I am financially responsible for any balance not covered by the insurance carrier.

ASSIGNMENT OF BENEFITS

I hereby assign and authorize my insurance benefits or claims to be paid directly to this office.

PATIENT NAME (PLEASE PRINT)

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

LAB PROCEDURES

This clinic may utilize an outside lab to process lab-related services that cannot be performed in our office. In that case you and/or your insurance company will receive a bill from the outside lab for your lab work.

To avoid out-of-network charges, **which will result in additional cost to you**, please let your doctor or the nurse know **immediately** if your health insurance policy requires us to send your lab work to another lab. Patients or guardians are responsible for communicating this insurance requirement to our staff at each appointment.

I have read and understand the above two Notices. I also understand that I will be responsible for all charges incurred related to out-of-network lab services.

Patient Name (please print)

Date

Patient/Guardian Signature

HISTORY FORM

NAME: _____

DATE OF BIRTH: _____

REVIEW OF SYMPTOMS: Please check any current symptoms you have.

Blood/Lymphatic

- Unexplained Lumps
- Easy Bruising/Bleeding

Breast

- Breast Lump(s)
- Nipple Discharge

Cardiovascular

- Chest Pain/Discomfort
- Palpitations
- Shortness of Breath

Neurological

- Headaches
- Memory Loss
- Fainting
- Clumsiness
- Disorientation
- Dizziness
- Lack of Coordination
- Involuntary Movement
- Numbness
- Paralysis
- Tingling
- Tremors
- Weakness

Ears/Nose/Throat/Mouth

- Difficulty Hearing/Ringing in Ears
- Hay Fever/Allergies/Congestion
- Trouble Swallowing

Endo

- Cold/Heat Intolerance
- Increase Thirst/Appetite

Eyes

- Change in Vision
- Eye Glasses
- Contact Lens

Genitourinary

- Painful/Bloody Urination
- Leaking Urine
- Nighttime Urination
- Elevated PSA

Musculoskeletal

- Muscle/Joint Pain
- Recent Back Pain

Psychiatric

- Anxiety/Stress
- Sleep Problems

Constitutional

- Recent Fever/Sweats
- Unexplained Fatigue/Weakness
- Unexplained Weight Loss/Gain

Respiratory

- Cough/Wheezing
- Snoring
- Coughing up Blood
- Daytime Drowsiness
- Use Oxygen Equipment
- Do not feel rested in the morning
- Use Nebulizer
- Use CPAP/BiPap
- Supplier of Equipment _____
- Pets - How many? _____ Type: _____
- Indoor/Outdoor: _____

Any Toxin Exposure?

- Asbestos
- Beryllium
- Lead
- Coal Dust

Gastrointestinal

- Heartburn/Reflux
- Blood or Change in Bowel Movement
- Nausea/Vomiting/Diarrhea
- Pain in Abdomen
- Hemorrhoids
- Loss of Bowel Control

Other: _____

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following medical problems (with dates)

- Heart disease: _____
- High blood pressure _____
- High Cholesterol _____
- Specify type _____
- Diabetes _____
- Thyroid problem _____
- Asthma/Lung disease _____
- Bladder/Kidney disease _____
- Bleed disorder _____
- Polyps (type) _____
- Kidney Stones _____
- Anemia _____
- Cancer (specify) _____
- AIDS _____
- Hemorrhoids _____
- Liver cirrhosis _____
- Blood Clots in Leg _____
- Peptic Ulcer _____
- Ulcerative colitis/IBS _____
- Pancreatitis _____

Other: _____

PERSONAL SURGICAL HISTORY: Indicate whether you have had any of the following surgeries (with dates and physician's name)

- Coronary artery bypass graft (open heart surgery) _____
- Cholecystectomy (gallbladder removed) _____
- Appendectomy (appendix removed) _____
- Hysterectomy (some/all of female reproductive organs removed) _____
- Tonsillectomy/Adenoidectomy (tonsils/adenoids removed) _____
- Colectomy (part of the bowel removed) _____
- Joint Replacement _____
- Stents in Vessels _____
- Hernia Repair (list type) _____
- Colonoscopy _____
- EGD _____
- Other _____

FAMILY HISTORY: Please indicate the current status of your immediate family members:

Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

- Cancer (specify type) _____
- High blood pressure _____
- Heart disease _____
- Stroke _____
- Genetic disorders _____
- Bleeding or clotting disorder _____
- Diabetes _____
- Asthma/COPD _____
- High Cholesterol _____
- Other: _____

SOCIAL HISTORY:

Tobacco Use

- Cigarettes Never Quit Date _____
- Current Smoker: packs/day _____ number of years _____
- Other Tobacco: Pipe Cigar Snuff Chew

Alcohol Use

- Do you drink alcohol? Yes/No _____
- Number of drinks/week _____

Caffeine Use

- Do you drink Coffee/Tea/Soft Drinks _____
- Number of drinks/day _____

Signature _____

Date _____

MEDICATION SUMMARY PAGE

NAME: _____ **TODAY'S DATE:** _____

DATE OF BIRTH: _____

NAME OF PRIMARY PHARMACY AND PHONE NUMBER: _____

DRUG/FOOD ALLERGIES:

MEDICATION NAME

DOSE

FREQUENCY

<u>MEDICATION NAME</u>	<u>DOSE</u>	<u>FREQUENCY</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
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_____	_____	_____
_____	_____	_____

GENERAL CONSENT FORM

SOUTHEAST REGIONAL PRIMARY CARE CORPORATION AND/OR ITS AFFILIATED ENTITIES OF WHICH THIS CLINIC IS ONE

Patient: _____ DOB: _____ Today's Date: _____

I, the undersigned, agree to the following:

(1) **CONSENT FOR MEDICAL TREATMENT**

I hereby voluntarily consent for care encompassing diagnostic, laboratory, imaging, examinations and surgical procedures and treatment by my physician, nurse practitioner (NP), physician assistant (PA) or his/her assistants, designees or consultants, as may be necessary in the judgment of my physician, NP, or PA. I also understand that I will be billed directly for those services provided. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made as to the results of the treatments or examination in this clinic. I understand that my medical record may be maintained and authorize access to persons involved in my care.

(2) **RELEASE FROM RESPONSIBILITY FOR LOSS OF VALUABLES**

Southeast Regional Primary Care Corporation (SRPCC) and this clinic (all-encompassing and hereinafter referred to as the "Clinic") are not responsible for valuables, including money, jewelry, cell phones, glasses, dentures, documents and other personal items.

(3) **RELEASE FROM RESPONSIBILITY**

If I should leave the Clinic against medical advice or prior to treatment being completed, I hereby relieve said physician and the Clinic of all liability for my action.

(4) **AUTHORIZATION FOR RELEASE AND USE OF MEDICAL INFORMATION FOR TREATMENT**

I authorize the Clinic or the Clinic's designee to disclose to payors including, but not limited to, insurers, workers compensation carriers, Centers for Medicare and Medicaid Services, or any other parties that may be liable for all or part of the Clinic's charges ("Third Party Payors"), all or part of my medical records as may be necessary to process payments for health care services provided. I authorize these payors to pay directly to the Clinic. I also authorize the Clinic to utilize my medical information, or to release all or part of my medical information to other health care providers consulted by my physician or the Clinic and utilization review nurse or case manager who may not be an employee of the Clinic, as may be necessary. I understand that the Clinic will take actions in reliance on this authorization to release medical information and that this information will be released only as reasonably necessary to carry out treatment, payment or Clinic and/or SRPCC system of entities operations.

(5) **NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have been given a copy of the Clinic's **Notice of Privacy Practices**. My signature below acknowledges receipt of a copy. I understand that the Clinic reserves the right to change the terms of its notice provisions and that I can obtain from the Clinic any revisions to this privacy policy.

(6) **ASSIGNMENT OF BENEFITS**

I hereby assign to the Clinic, or its duly authorized agents and/or assigns, all rights, benefits and interests in all proceeds from all Third Party Payors for the payment of all charges associated with my treatment. I further authorize the Clinic to take all necessary actions to ensure that any insurance benefits otherwise payable to me, or my estate, are paid directly to the Clinic. This authorization includes, but is not limited to billing insurance, filing petitions, filing suit in name or on behalf of the Clinic or SRPCC or its assignees, filing proofs or claim, filing probate claims and filing grievances and all other similar procedures. I agree to provide and sign any other documents that may be reasonably necessary to accomplish any of the above purposes. I understand that any amount paid in excess of regular charges will be refunded as appropriate to the Third Party Payor, the patient or guarantor.

(7) **FINANCIAL RESPONSIBILITY AGREEMENT**

I understand that I am financially responsible to the Clinic and its lawful assignees for all charges not covered or paid by insurance. I also understand and agree that all deductibles, coinsurance, non-covered charges, and other items not paid by insurance, self-insured health plans or other Third Party Payor are due and payable upon services based on the best estimates available as determined by the Clinic. Charges remaining on this account are payable upon demand. Unless payment is made in full at the time of service, then patient authorizes the Clinic or its agents to obtain a credit report. Should the account be referred for collection to a collection agency, the undersigned agrees to pay all court costs of collection may include reasonable attorney fees of up to and including 15% of the debt involved. The undersigned patient and insured also agree that the Clinic or SRPCC or its assignees may apply any payments received from the patient against any other amounts due at the time from or for the undersigned patient. All amounts not paid when due may accrue interest at the rate of 1½% per month on the unpaid principal balance. If applicable, I certify that the information provided to the Clinic in requesting payment under Title XVIII and Title XIX of the Social Security Act is correct.

(8) **NON-CERTIFICATION OF SERVICES**

I hereby agree that as the policyholder or patient, I share the responsibility of assuring certification is obtained from the insurance company on the above party for any services indicated. If certification is not obtained, I further agree that in the event the insurance denies either all or part of their payment on the clinic account, I will pay the account in full upon demand.

(9) **CONSENT TO PHOTOGRAPH, VIDEOTAPE OR OTHER IMAGING**

I authorize the clinic to photograph, videotape or digitally image me as appropriate for medical record identification purposes and/or to document my medical condition. I release the Clinic, its physicians, employees and agents from any liability in the making and use of these requested photographs, videos, or digital images.

(10) **MEDICAL EXCHANGE OF INFORMATION**

I hereby authorize the Clinic to store my information electronically and to exchange this information within the medical community (e.g. pharmacy, lab, hospital, referring provider) to continue my medical care.

(11) **METHODS OF CONTACT**

I authorize you to use and disclose Protected Health Information to contact me to remind me that I have an appointment for medical care, communicate with me regarding scheduled medical care, or to contact me to tell me about possible treatment options or alternatives or health related benefits and services that may be of interest to me. I authorize you to make this contact via any means which I have provided including, but not limited to, telephone number, wireless telephone number, voicemail, text messages, or email address(s) provided by me.

I agree, in order for you to service my account or to collect any amounts I may owe, you and/or any agents used by you, may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, cell phones, voicemail, which could result in charges to me. You and/or any agents used by you, may also contact me by sending text messages or e-mails, using any e-mail address I provide to you. I acknowledge that methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

(12) **PATIENT PORTAL AND EMAIL CONSENT**

I agree that I may be provided with an opportunity to participate in and/or use the Southeast Regional Primary Care Patient Portal and that the email address I provide at registration may be used for Patient Portal communications and access. I am providing consent for Southeast Regional Primary Care to communicate with me regarding my Protected Health Information via this Patient Portal. I understand that my health information is protected by federal and state law. This consent applies to records which may contain information related to the testing, diagnosis, or treatment for conditions including, but not limited to, drug and alcohol abuse; psychotherapy, mental or other behavioral health; HIV/AIDS or other communicable diseases; genetic testing; or any other condition expressly protected by Georgia Law. This consent will remain in effect unless I deactivate my (Patient Portal) account or provide written notice to Southeast Regional Primary Care Corporation.

I understand that my username and password will be unique to my health information and sharing my username and password may grant others access to my health information. I further understand that any health information disclosed as a result of sharing my username and password may no longer be protected under federal or state law and could be further released by the individual who receives the information.

(13) **ACKNOWLEDGMENT**

My signature below constitutes my acknowledgment and agreement that I read and understand the above, was given the opportunity to discuss this form and ask questions, that all questions were answered to my satisfaction, and I am satisfied I understand the form's contents and significance. I understand that this consent form will be valid and remain in effect as long as I am a patient of the Clinic.

I certify that I have read the foregoing, and I am either the patient or am duly authorized by the patient's general agent to execute the above and accept the terms.

Signature of Patient or Authorized Individual

Date

Relationship of Signer to Patient:

(self, mother, father, son, daughter or explain other)

Guarantor of Payment (If patient not signing)

If patient is unable to sign, state reason: _____

Witness

Date