Welcome to Middle Georgia Family Health

Last Name _____ **First** _____**M.I.** _____

Sex: M F **Date of Birth**_____ **What do you like to be called?**_____

Marital Status: S M D W **SS#**_____ **License#**_____

Street Address_____

City_____ **State**_____ **Zip**_____

Home ( )_____ **Cell ( )**_____ **Email** _____

Employment Information **Full Time** **Part Time** **Unemployed** **Retired** **Student**

Place of Employment_____**Position**_____

Street Address_____**Work Phone ( )**_____

Emergency Contact Name:_____ **Relationship to patient**_____

Street Address_____

City_____ **State**_____ **Zip**_____

Home( )_____ **Cell( )**_____ **Work ( )**_____

Pharmacy Name: **Location:** **Phone (Optional):**

Primary Health Insurance Carrier Name:_____ We do not accept Medicaid
Copay $ *Group #* *Policy #*

****Policyholder Information**(If other than self)**
Policyholder Name: *Relationship to patient:*

Date of birth: *Social Security Number:*

Secondary Health Insurance Carrier Name: _____ We do not accept Medicaid
Copay $ *Group #* *Policy #*

****Policyholder Information** (If other than self)**
Policyholder Name: *Relationship to patient:*

Date of birth: *Social Security Number:*

Race: White, American Indian, Asian, African American, Native Hawaiian, 2 or more races
Ethnicity: Non-Hispanic, Hispanic

I have received a Notice of Privacy Practices for Middle Georgia Family Health (MGFH).
I agree to pay a no-show fee of $30.00 for all appointments missed without first notifying MGFH.
I agree to pay a $25 fee for paperwork requiring the doctor's signature and / $50 for FMLA paperwork.

X_____ _____

Signature **Date**

PERSONAL AND FAMILY MEDICAL HISTORY				
Please check the appropriate boxes and answer the questions.	***Cancer*** *What Type?*	***Diabetes*** Insulin/ Non insulin Dep.	***Heart Disease***	***Other***
Patient				
Mother				
Maternal Grandmother				
Maternal Grandfather				
Father				
Paternal Grandmother				
Paternal Grandfather				
Siblings				

Do you use tobacco? ☐ No ☐ Yes, _____ packs per day

Have you used tobacco in the past? ☐ No ☐Yes, quit when?_____(year)

Do you use alcohol? ☐ Never ☐ Rarely ☐ Social Drinker _____ Drinks per week

Are you allergic to any medications? □ No □ Yes,_____

Ongoing Medical Problems:

Surgeries, including year:

Current Medications, including strength and dosage:

Are you seeing any specialists?

Consent for Medical Treatment:

The undersigned hereby authorize the providers associated with Middle Georgia Family Health to furnish the necessary treatments, surgical operation, x-ray examinations, drugs and supplies, and diagnostic procedures ordered by the attending physician. I acknowledge that no assurance has been made to me as to the results of treatment.

Authorization for Release of Medical Information

Authorization is hereby granted to the providers associated with Middle Georgia Family Health to release to my insurance company or companies, their agents, or other third party payers. Confidential information (including copies of records) as may be required or necessary for the completion of claim processing relative to my treatment.

Assignment of Insurance Benefits and Guarantee of Payment

The undersigned hereby assigns and authorizes payment directly to Middle Georgia Family Health of the insurance benefits otherwise payable to the undersigned. The undersigned remains financially responsible for any charges not covered by this assignment of insurance benefits and personally guarantees payment of any amounts not paid by insurance.

_____ _____

Patient Date

____
Guarantor/Authorized Person

Patient Financial Responsibility

I acknowledge full financial responsibility for services rendered at Middle Georgia Family Health (MGFH). I understand that I am responsible for prompt payment of any portion of the charges not covered by my insurance, including co-insurance, deductibles, and co-pays. I understand payment of co-pays is expected at time of service, as well as any prior balance I may owe. I also consent that the payment of authorized medical insurance benefits be made on my behalf directly to MGFH for any medical services rendered.

_____ _____

Signed Date

Consent for Purpose of Treatment, Payment, and Healthcare

I hereby give my consent to Middle Georgia Family Health (MGFH) to use or disclose, for the purpose of carrying out treatment, payment, or healthcare operations all protected health information contained in the patient record. For more detailed description of the consent and other uses and disclosures please review our Notice of Privacy Practices. I understand that MGFH reserves the right to change its privacy practices that are described in this notice. I understand that this consent is valid until it is revoked by me. I understand that I will not be able to revoke this consent in cases where the provider has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the provider's office.

_____ _____

Signed Date

Prescription Policy

Any medication filled at a local pharmacy should be called into that pharmacy in a timely enough manner for the pharmacist to check your medication and dose, fax a request or phone for a refill, and receive a reply from our office. **Please allow us at least 72 hours (3 Business Days) for this process**. You will be responsible for calling your pharmacy to ensure your prescription has been filled, we will not call you back with this information. Be sure to call your pharmacy a week prior to running out of your medication to ensure that you do not go without it. Make sure to inquire about all refills during your appointment time.

In order for our Physicians and PA's to make a correct diagnosis, you must be seen in our office. With this understanding, **we will not return calls requesting an antibiotic or an extension of an antibiotic.** Schedule an appointment to be seen.

Please notify us if you have a prescription that requires 90 days for mail in, or a prescription that will be filled on RAFB. These need to be drafted and signed. We will not fax mail order forms to your mail order pharmacy. This is your responsibility.

Any need for continuing use of controlled medications will be addressed on an individual basis. An adequate amount will be dispensed until your next visit, **no exceptions will be made for refills before that time. You MUST be seen for pain medications.**

Please be sure to bring ALL your medications (in the proper bottles) to your appointments so we may ensure we have the correct medications for you on file.

_____ _____

Print Patient Name Date

_____ _____

Patient Signature D.O.B.

Authorization for Use or Disclosure of Protected Health Information

Choose A or B

A. I **do not** authorize the use/disclosure of health information about me. _____
(Initial and go directly to signature line)

B. I **do** authorize the use/disclosure of health information about me as described below: _____
(Initial and complete 1 thru 3 and sign below)

1. Person(s) or class of persons authorized to use/disclose the information:
   - ❑ Employee of Middle Georgia Family Health
   - ❑ _____

2. Person(s) or class of persons authorized to receive the information:

Name:	Relationship:	DOB:
Name:	Relationship:	DOB:
Name:	Relationship:	DOB
Name:	Relationship:	DOB

3. Description of information that may be used/disclosed:

   - ❑ All health information, past and present, no exclusions.
   - ❑ Appointment dates and times only.
   - ❑ Other (be specific):

   _____
   _____
   _____

This authorization is valid until written withdrawal.

_____ _____
PATIENT NAME (PRINT) Date of Birth

_____ _____
PATIENT SIGNATURE Date

_____ _____
EMPLOYEE WITNESS Date