Peachstate Family Clinic

DEMOGRAPHIC INFORMATION

Patient Name:		**Previous Name:**	
Date of Birth:		**Email:**	
Social Security Number:		**Mailing Address:**	
City / State / Zip:		**Home Phone:**	
Cell Phone:		**Work Phone:**	
Gender:	M / F	**Marital Status:**	S / M / D

Race: _____ Language: _____

OK to Leave Message: **Yes / No** Home / Cell OK to Send a Text: **Yes / No**

EMERGENCY CONTACT INFORMATION

Name	Number	Relationship to Patient

HIPAA: Please identify the person, if any, whom you authorize to receive medical information about you:

_____

GUARANTOR / RESPONSIBLE PARTY

Name	
Guarantor Date of Birth	
Guarantor Address	

INSURANCE INFORMATION (Let us know if you have secondary insurance)

Insurance		**Group Number**	
Subscriber Number		**Insured's Name**	
Insured's Date of Birth		**Insured's Relationship to Patient**	
Insured's Address			
Secondary Insurance (if applicable)		**Policy / Member ID**	

PHARMACY INFORMATION

Pharmacy Name / Location / Phone: _____

Authorization: I attest that the above information is correct and have read and understand the policies of Peachstate Family Clinic. I accept my responsibility as stated in those policies. I authorize release of information necessary for my insurance company to process my claim. I also authorize the clinical staff of Peachstate Family Clinic to view my medication history from external sources.

Patient Signature: _____

For patients under 18, signature of Parent/Guardian is required.

Relationship to Child: _____ Date: _____

Medical History Form

Name: _____ Date of Birth: _____

CURRENT MEDICATIONS

Medication	Dose	Frequency

MEDICAL HISTORY - Please check all that apply

☐ Allergies	☐ Chest Pain	☐ GI Disorder	☐ Kidney Disease	☐ Sexual/Menstrual Dysfunction
☐ Anemia	☐ Cholesterol	☐ Gout	☐ Lactose Intolerance	☐ Shortness of Breath
☐ Arthritis	☐ Depression	☐ Headache	☐ Mental Illness	☐ Stroke
☐ Asthma	☐ Diabetes	☐ Heart Murmur	☐ Osteoporosis	☐ Thyroid Disease
☐ Bleeding Disorder	☐ Dizziness	☐ Heart Palpitations	☐ Peripheral Vascular Disease	☐ Ulcer
☐ Bowel Irregularity	☐ Epilepsy/Convulsions	☐ Hepatitis	☐ Pneumonia	☐ Venereal Disease
☐ Bronchitis	☐ Gallbladder Disease	☐ High Blood Pressure	☐ Prostate Disease	☐ HIV
☐ Cancer	☐ Glaucoma	☐ Incontinence	☐ Rheumatic Fever	☐ Other

DRUG ALLERGIES / TYPE OF REACTION

_____

HOSPITALIZATIONS OR SURGERIES - REASON / DATE

FAMILY HISTORY

Family Member	Status	Cancer	Diabetes	Heart Disease	Hypertension	Mental Illness	Thyroid Disease	Unknown
Father								
Mother								
Grandparents								
Siblings								
Children								

SOCIAL HISTORY

Smoking? **Yes / No** When started/stopped? _____

Alcohol? **Yes / No** When started/stopped? _____

Do you exercise? **Yes / No** How often? _____

Sleep: _____

Do you have a living will? **Yes / No**

Peachstate Family Clinic Policies

Financial Policy

Thank you for choosing us as your primary care provider. It is a privilege to serve your medical interest and we look forward to doing so. Please understand that payment for service is an important part of the provider-patient relationship. If you do not have insurance or proof of insurance, you will have to pay cash for any services needed in advance or at the time of service. We accept cash, debit card, or credit card. If financial arrangements or medical necessities are not kept in good faith, you will be notified by regular or certified mail that you have 30 days to find alternative medical care. If your account is placed with an outside collection agency, you will be charged with the full amount of collection fees, attorney fee, allowable court costs, as well as termination of your care with our office.

Insurance

Your insurance policy is a contract between you and your insurance carrier. The balance of your claim is your responsibility whether your insurance company pays your claim. It is your responsibility to provide all necessary insurance eligibility, identification, authorization and referral information and to notify our office of any information changes when they occur. Preauthorization of services does not guarantee payment from your insurance carrier. We also require photo identification when accepting insurance information. It is the patient's responsibility to know if our office is participating or not participating with their insurance plan. When insurance is involved, we are contractually obliged to collect copayments, coinsurance, and deductibles, as outlined by your insurance carrier. If there is a balance due on your account, we will mail a detailed statement which is due upon receipt. Do not assume that any statement you receive will be paid by your insurance company.

Miscellaneous Forms, Additional Information and Authorizations

We will provide all necessary information to have your benefits released for free. However, if there are forms that need to be completed and you have not been seen within one week, we will require that you be seen to have the provider complete the forms after a face-to-face office visit.

Missed Appointment

If you fail to keep your appointments without notifying us 24 hours in advance, a missed appointment fee may apply. These fees are typically **$35**. Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide care to other patients.

Medical Records Fees

As permitted by HIPAA, our medical record fees are a reasonable cost-based fee for copies, including the copying, supplies, labor, and postage of the files, and/or summaries.

Treatment

Our providers treat patients based on medical necessity and not on insurance coverage. It is the patient's responsibility to know your benefits and coverage. We will obtain any prior authorizations obtained from your insurance carrier; however, this may not guarantee payment and does not define patient responsibility amounts.

Initials: _____

Follow-Up Plan

Patients and provider will discuss, document, and put into action a follow up plan for the necessary patients. It must be agreed upon between provider and patient. It will include medical updates, treatment plans and goals, and follow up dates for medications and prescription refills.

Prescription Refill

All prescription medications should only be taken as prescribed, to ensure that you don't run out before you follow up appointment. There will be enough medication prescribed until the next follow up appointment. No refill will be given before the next follow up appointment unless there is an emergency.

I have read and understand the above policies. I agree to assign insurance benefits to Peachstate Family Clinic whenever applicable. I also agree, in addition to the amount owed, I will also be responsible for the fee charged by the collection agency for costs of collections if such action becomes necessary.

Emergency Plan

In case of an emergency or if you are experiencing life threatening symptoms such as chest pains or difficulty breathing, etc., please call 911 instead of contacting the office. It is the patient's responsibility to call 911 as soon as possible so that the ER can evaluate and monitor your symptoms.

Printed Name of Patient: _____

Signature of Patient or Authorized Representative: _____

(If under 18 yrs old, must be parent or guardian)

Relationship to Patient: _____

Date: _____

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

To address any special needs you may have and to assure your patient information is kept confidential, please answer the following questions:

Other than yourself, do you authorize our office to discuss your health information with another family member or spouse? **YES / NO**

If so, please list names below for our record.

Name	Relationship	Phone

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Reason: _____

_____

Staff Initials: _____ Date: _____