Peachstate Family Clinic

DEMOGRAPHIC INFORMATION

Patient Name: ____________________ **Previous Name:** __________ **Date of Birth:** ______

Email: ____________________________ **Social Security Number:** ________________

Mailing Address: __________________________ **City:** __________ **State:** ___ **Zip Code:** ____

Home Phone: ______________ **Cell Phone:** _____________ **Work Phone:** ____________

Gender: M/F Marital Status: S/M/D, Race: White/ Black/ Hispanic/Asia Language ________

OK to Leave Message: ______ **Home** ____ **Cell** ____ **Ok to Send a Text** _____

EMERGENCY CONTACT INFORMATION

Name: ____________________ **Number:** ____________ **Relationship to Patient:** _______

HIPAA (Please circle name if you authorize this person 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 Rel to Pt:** ________

Insured's Address: ____

PHARMACY INFORMATION

Pharmacy Name/Location/ phone: ____

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

____

Patient Signature (18 and under requires signature of Parent/Guardian)

____

Relationship To Child ____________ **Date** ______

Medical History Form

Name: ______________________ **Date of Birth:** ______________

CURRENT MEDICATIONS

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

DRUG ALLERGIES/TYPE OF REACTION

HOSPITALIZATION OR SURGERIES **REASON/DATE**

FAMILY HISTORY

	STATUS	CANCER	DIABETES	HEART DISEASE	HYPERTENSION	MENTAL ILLNESS	THYROID DISEASE	UNKNOWN
FATHER								
MOTHER								
GRANDPARENTS								
SIBLINGS								
CHILDREN								

SOCIAL HISTORY
Smoking? Yes No **When started/stopped?** **Do you exercise?** Yes No **How often?**
Alcohol? Yes No **When started/stopped?**
Sleep: Do you snore?
Do you have a living will?

Peachstate Family Clinic Policies

Financial Policy

Thank you for choosing us as your primary care provider. It 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 agreements 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 appointment unless there is an emergency.

I have read and understand the above policies. I agree to assign insurance benefits to Peachtree Family Clinic whenever applicable. I also agree, in addition to the amount owed, I also will 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? Circle one YES NO
If so, please list names below for our record.
Name: ____________________ Relationship: __________ Phone:________________

Name: ____________________ Relationship: __________ Phone: ________________

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: ____________________