SOUTHERN
FAMILY MEDICINE

Patient Information			
Last Name:	First Name:		MI:
DOB:	Age:	Social Security Number:	
Address:			
City:	State:	Zip Code:	
Home Phone:	Cell Phone:		
Gender: ☐ Male ☐ Female ☐ Transgender	Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed		
Student: ☐ Not a student ☐ Full Time ☐ Part Time	School:		
Employer Name:	Work Phone:		
Employer Address:			
City:	State:	Zip Code:	

Emergency Contact Information		
Emergency Contact:	Relation:	Ok to release Medical Information? ☐ Yes ☐ No
Home Phone:	Cell Phone:	
Emergency Contact:	Relation:	Ok to release Medical Information? ☐ Yes ☐ No
Home Phone:	Cell Phone:	
Power of Attorney:	Relation:	Phone Number:
Do you have a Living Will? ☐ Yes ☐ No	Do you have a DNR (do-not-resuscitate order)? ☐ Yes ☐ No	

Insurance Information		
Primary Insurance Name:	Subscriber Number:	
Insurance Company Address:	City:	State/Zip:
Group Number:	Guarantor:	
Guarantor Social Security Number:	Guarantor DOB:	
Secondary Insurance Name:	Subscriber Number:	
Insurance Company Address:	City:	State/Zip:
Group Number:	Guarantor:	
Guarantor Social Security Number:	Guarantor DOB:	

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Medical History					
CONDITION	**YOU**	**RELATIVE**	**CONDITION**	**YOU**	**RELATIVE**
High Blood Pressure			Migraine Headaches		
Heart Attack			Seizures		
Congestive Heart Failure			Kidney Problems		
Asthma			Stomach Ulcer		
Emphysema/COPD			Gallstones		
Tuberculosis			GERD/Reflux		
Diabetes			Constipation		
Thyroid Disease			Depression		
Anemia			Mental Illness (Please list)		
Leukemia			Arthritis		
Sickle Cell			Glaucoma/Eye Problem		
Bleeding Problems			Cancer		

Other Current or Past Medical Conditions Not Listed Above		

Current Medications					
Local Pharmacy:			***Telephone:***		
Mail Order Pharmacy:			***Telephone:***		
MEDICATION	**STRENGTH**	**DIRECTIONS**	**MEDICATION**	**STRENGTH**	**DIRECTIONS**

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Medication Allergies	
MEDICATON	**REACTION**

Surgical History		
Type/Location	**Doctor**	**Date**

Hospitalization	
Hospital/Year	**Reason**

Social History		
Do you use tobacco products? □Yes □ No	What Kind? □ Cigarettes □ Chewing tobacco □ Electronic Cigarettes □ Snuff	
How much do you use daily?	How long? (Years/Months)	Interested in quitting? □Yes □ No
Do you consume Alcohol? □Yes □ No	How often: □ Seldom □ Socially □ Daily	What kind?
Mother : □ Alive □ Deceased	Cause of Death:	
Father : □ Alive □ Deceased	Cause of Death:	
Siblings: □ Yes □ No	Number of Brothers:	Number of Sisters:
Children: □ Yes □ No	Number of Sons:	Number of Daughters:
Do you see a specialist? □ Yes □ No	Doctor's Name & Specialty:	
Specialist continued:		

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OBGYN HISTORY	
Who is your current OBGYN Physician?	Phone number:
Age of First Menstrual Cycle:	Last Menstrual Cycle Start Date:
Average Length of Cycle:	Do you have a heavy or light cycle?
Do you experience any vaginal discharge?	Do you experience pain during intercourse?
Do you use birth control?	Birth Control Method:
Have you had any abnormal testing (PAP)? If so, please include dates:	
Number of Pregnancies:	Number of Live Births:
Number of Terminated Pregnancies and Reason (such as miscarriage, abortion, still births, etc) :	
Do you have a history of pregnancy complications? If so, please specify:	

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In effort to keep your medical record updated, we ask that you please list the following for the exams outlined below: date of last known exam, where exam was performed, and who ordered the exam.

TEST	DATE	LOCATION	ORDERING PROVIDER
Colonoscopy			
Mammogram			
PAP			
DEXA (bone density)			
PSA (prostate)			
Zoster Vaccine (shingles)			
Flu Vaccine			
Tdap Vaccine			
Pneumonia Vaccine			
Spirometry (Pulmonary Function Test)			
Chest X-ray			
EKG			
ECHO			
Cardiac Stress Test			
PPD (Tuberculin Skin Test)			
Diabetic Foot exam			
Diabetic Eye Exam			
General Eye Exam			
EGD			

FINANCIAL POLICY:

It is our firm belief that all patients who come to this office expect and deserve quality medical care. In order for us to provide this level of service, it is important that our patients understand our financial policies.

1. We are providers for many insurance plans. If we are a participating provider in your plan, we will be listed in your group's provider list or preferred provider directory. It is your responsibility to know if we are in your network. We will bill your insurance company directly and receive payment from them directly. Most plans require a co-payment per visit, coinsurance, and/or have yearly deductibles. We require that such payments be made at the time that you receive services (upon check-in).

2. If your insurance requires approval, necessary documentations will be your responsibility. You must give your referral form and/or number to the receptionist when you check-in to see the doctor. If your insurance company does not pay your bill because of improper referrals, you will be responsible for the full bill.

3. If your insurance is up-to-date, we will file up to two separate insurance claim forms for services you receive. It is your responsibility to tell us about changes in your insurance; therefore, we require copies of your insurance cards at each visit. These forms are processed on a daily basis and are sent to your insurance company. We are happy to help you by submitting insurance claims. It is important to remember that your insurance is a contract between you and your insurance company. Although we file claims for you, you are still responsible for your bill regardless of the amount your insurance company pays, except in cases of pre-negotiated insurance agreements and where legally prohibited.

4. If you do not have insurance, full payment is expected at the time you receive services. Payment will be accepted by cash, check, or credit card (Visa, MasterCard, and Discover). Returned checks will result in a $30.00 charge being added to your account. In addition, your check may be sent to small claims court for collection.

5. Please remember when you receive your statement, you have already received healthcare from our physicians, and we have initiated your insurance claim. We ask that you promptly pay in full your portion of the balance due. If your account is turned over to collections, you will be responsible for all collection/court costs incurred.

6. Southern Family Medicine does not accept letters of payment from any third party. All co-pays must be paid at each and every visit. In the event accident treatment is not a covered service under your (health) insurance policy, any balance due must be paid in full at the time services are rendered. In the event we are uncertain as to whether your policy covers treatment for motor vehicle accidents, we will bill the carrier. If the carrier denies coverage, then the patient will be billed with the expectation of prompt payment.

7. In the event that this practice must bill the patient for any service(s) rendered, prompt payment is always expected. All statements/bills which go unpaid for thirty (30) days will begin accruing a late fee of 1.5%. This finance charge is non-negotiable.

8. Your section initials and packet signature authorizes SOUTHERN FAMILY MEDICINE to act as your representative in the case of appeals or other insurance negotiations.

_____ Patient's Initials
Agreeing to above statements

SOUTHERN
FAMILY MEDICINE

OFFICE POLICIES & PROCEDURES

In order for us to provide quality medical care for all patients, we feel that it is important that our patients understand our office policies and procedures as they pertain to patients.

OFFICE HOURS:

Our office is open Monday through Friday. Our hours are 8:00 AM to 5:00 PM. Phone calls can be taken during this time, and will be returned as soon as possible. If you have not received a return phone call within 24 hours, please contact the clinic supervisor. In case of an emergency after hours, please call 911 or go to your nearest emergency room.

CONFIDENTIALITY:

Please rest assured that our office staff is trained to keep patient information strictly confidential. Absolutely no information about you or your treatment will be released to anyone without your written authorization or consent. In turn, we also ask that you respect the confidentiality of other patients by not discussing people you see in our office.

I have been offered and read a copy of the Notice of Privacy Practices of Southern Family Medicine. I authorize the release of any information concerning my health care, advice, and treatment provided for the purpose of evaluation and administering claims for insurance or workman's compensation benefits.

_____ Patient's Initials

IMMUNIZATION RECORDS:

I authorize the Georgia Department of Community Health (or similar state for federal agency) to release any immunizations records related to the above mentioned patient. Furthermore, I authorize Southern Family Medicine to release to the aforementioned agency notification of any immunizations I obtain through my treatment at Southern Family Medicine.

_____ Patient's Initials

PRESCRIPTION RENEWALS:

To the extent possible, we ask that you request prescription refills at the time of your visit. If you do need a refill, please call your pharmacy and they will contact us to refill your prescriptions. Please do not wait until you take your last pill before you call for a refill. To avoid running out of medication, please notify your pharmacy at least 48 hours in advance and please check with your pharmacist to see if your medication is ready.

For written Prescriptions; please notify our office 2-3 days in advance when you need a refill.

_____ Patient's Initials

PAYMENT FOR SERVICES:

I acknowledge full financial responsibility for services rendered. I understand that my co-payment is due upon check-in and prior to services being rendered. I understand that payment in-full is due at the time services are rendered. If at any time my account is turned over to a collection agency, I agree that Southern Family Medicine has the right to charge me all fees associated with my debt collection. If for any reason my insurance claim is processed and is denied or determined to be invalid, I am responsible for the full balance on the account. I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance information.

If you do not have insurance, you are responsible for your payment in full. If you anticipate having difficulty with payments, please notify our office manager, Josh Braun. As a courtesy to you, our office will file claims with your insurance company. However, we cannot be responsible for collecting or negotiating settlements of disputed claims. Therefore, you are responsible for any balance left on your account that your insurance does not cover.

_____ Patient's Initials

CANCELLATIONS:

Your appointment is a specific period of time reserved just for you. If you need to cancel, we ask that you call our office 24 hours prior to your scheduled appointment time.
Three NO SHOWS may result in termination from our practice and repetitive rescheduling in excess of normal request may result in our office making you a walk-in only patient or in rare cases, termination from our practice. This policy is designed to help our office provide timely and efficient medical care.

_____ Patient's Initials

LABORATORY:

ALL labs will be sent to Laboratory Corp. of America (LabCorp). All SELF-PAY patients will be responsible for the laboratory testing, charges, and fees, including a drawing fee, at the time services are rendered. If for any reason our office should need to bill you for laboratory charges, a **$5.00 service charge** will also be applied to your account. If your preferred lab is Quest or a local hospital, please inform our staff and we will accommodate all reasonable request.

_____ Patient's Initials

RIGHTS/RESPONSIBILITIES:

SOUTHERN FAMILY MEDICINE

SOUTHERN FAMILY MEDICINE recognizes the importance of basic rights of all patients. At the same time, SFM has the right to expect reasonable and responsible behavior on the part of the patients, their relatives, and friends. The following rights and responsibilities of patients are, therefore, considered reasonable, and SFM will endeavor to protect the same.

PATIENT RIGHTS:

1. To be afforded impartial access to treatment regardless of race, creed, sex, national origin, handicap condition, or age and to be treated with respect and dignity at all times.
2. To refuse to talk with or see anyone not directly involved in the patient's care or treatment.
3. To wear appropriate clothing and/or religious symbols, as long as such clothing and/or symbols do not interfere with treatment or diagnostic procedures.
4. To be interviewed and examined in privacy and to have someone of the patient's own gender present if requested.
5. To expect that his or her care and treatment be handled in confidence and that his or her medical record will be read only by authorized individuals.
6. To expect that our office practices and its environment are reasonably safe at all times.
7. To know the identity of all persons providing service to him or her and the identity of the physician who is primarily in charge of his/her care.
8. To expect complete and current information concerning his/her diagnosis (if known), treatment and prognosis is in understandable terms.
9. To expect that diagnostic procedures or treatments will be performed only with consent.
10. To request, at his/her own expense, a consultation with a specialist.
11. To refuse treatment with the understanding that the office/patient relationship may be terminated with reasonable notice, and to refuse transfer to another facility.
12. To request and receive an itemized and detailed explanation of his/her bill.
13. To initiate a complaint at any time during the course of treatment and to expect that it will be reviewed and resolved, if possible, in a reasonable period of time.
14. To have pain assessed and managed, and to have information about pain and pain relief measures.

PATIENT RESPONSIBILITIES:

1. To provide accurate and complete information about your current complaints, past illnesses, medications, and financial status.
2. To comply with all office rules and regulations; to follow the orders of your provider and to be responsible for your own actions and outcomes if you refuse treatment or do not follow instructions.
3. To assure that the financial obligations of your healthcare are fulfilled promptly.
4. To be considerate of the rights of others and to assist us in controlling noise, the number of visitors allowed, and any other distractions, that may affect patient care.
5. To accept responsibility for all personal property and valuables brought into the office.
6. To ask your doctor or nurse what to expect regarding pain and pain management; to discuss pain relief options with your doctor or nurse; to ask for pain relief when pain first begins; to help the doctor and nurse measure your pain and to tell the doctor and nurse if your pain is not relieved.
7. To report any risks in your care and any unexpected changes in your health condition.
8. To help the clinic improve services by providing feedback about your healthcare needs and expectations.

Patient Signature: _____ Date: _____

By signing above, I acknowledge that I have read and understand the above statements.

Informed Consent for Medical Student Education

Southern Family Medicine is a teaching practice, and students may be involved in the delivery of health care. Medical and nursing students learn under the supervision of registered healthcare professionals. Contact with patients throughout their journey towards furthering their education in the healthcare field is a vital portion of their learning experience. Medical and nursing students may be involved in the interview or observation of procedures. All students are held to HIPAA regulations to ensure the security of personal information and patient confidentiality.

_____ I agree to have medical students involved in the interview process or observation of procedures.

_____ I **DO NOT** wish to have a medical student involved in my treatment.

Print Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

*Patients may revoke this agreement at any visit if they prefer based on their specific compliant or desire for modesty. Thank you in advance for your participation in educating our future health professionals.