MEADOWS HEALTH
WOMEN'S CENTER

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

Date: _____ **Primary Physician** _____ **Pharmacy:** _____

PATIENT INFORMATION

_____
First Name Middle Last Name

_____ _____ _____
Other Names Used Email Address Marital Status (S, M, W, Sep, D)

May we contact you via email? Please circle ◯ Y or ◯ N. If no, what is your preferred method of communication?

Please circle Telephone or regular mail.

___/___/___ ◯ M or ◯ F _____ _____ _____ ____-____-____
Date of Birth (MM/DD/YY) Sex (Check One) Race Primary Language Ethnicity Social Security No. (XXX-XX-XXXX)

_____
Patient Mailing Address (Street, Route, Apt. No.) City State Zip Code

_____
Primary Phone Number Secondary Phone Number ***Please provide at least two (2) phone numbers**

_____
Emergency Contact Name Phone Number (Must be different from primary phone number on file) Relation to Patient

INSURANCE INFORMATION

_____
Primary Insurance Co. Name Policy Number Group/Plan Number Social Security No. of Policyholder

_____
Policyholder's Name Date of Birth (MM/DD/YY) Employer Relation to Patient

_____
Secondary Insurance Co. Name Policy Number Group/Plan Number Social Security No. of Policyholder

_____
Policyholder's Name Date of Birth (MM/DD/YY) Employer Relation to Patient

How did you hear about our office? Check One:
◯ Referring Doctor ◯ Newspaper ◯ Billboard ◯ Radio ◯ Phone Book ◯ Website
◯ Friend - Who may we thank: _____
Other: _____

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**

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.

Print Name _____ Date _____

Signature_____ DOB _____

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

1._____ 3._____ 5._____

2._____ 4._____ 6._____

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

Ears/Nose/Throat/Mouth
- ☐ Difficulty Hearing/Ringing in Ears
- ☐ Hay Fever/Allergies/Congestion
- ☐ Trouble Swallowing

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

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

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

Breast
- ☐ Breast Lump(s)
- ☐ Nipple Discharge

Endo
- ☐ Cold/Heat Intolerance
- ☐ Increase Thirst/Appetite

Musculoskeletal
- ☐ Muscle/Joint Pain
- ☐ Recent Back Pain

Skin
- ☐ Rash
- ☐ New or Change in Mole

Respiratory
- ☐ Cough/Wheezing
- ☐ Coughing up Blood
- ☐ Use Oxygen Equipment
- ☐ Use Nebulizer
- ☐ Use CPAP/BiPap
- ☐ Supplier of Equipment _____
- ☐ Pets - How many? ____ Type: _____
  Indoor/Outdoor:_____

Cardiovascular
- ☐ Chest Pain/Discomfort
- ☐ Palpitations
- ☐ Shortness of Breath

Eyes
- ☐ Change in Vision
- ☐ Eye Glasses
- ☐ Contact Lens

Psychiatric
- ☐ Anxiety/Stress
- ☐ Sleep Problems

- ☐ Snoring
- ☐ Daytime Drowsiness
- ☐ Do not feel rested in the morning

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

Any Toxin Exposure?
- ☐ Asbestos
- ☐ Beryllium
- ☐ Lead
- ☐ Coal Dust

Other:_____

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following medical problems (with dates)
- ☐ Heart disease:
- ☐ Specify type _____
- ☐ Asthma/Lung disease
- ☐ Polyps (type) _____
- ☐ Cancer (specify) _____
- ☐ Liver cirrhosis
- ☐ Ulcerative colitis/IBS
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Bladder/Kidney disease
- ☐ Kidney Stones
- ☐ AIDS
- ☐ Blood Clots in Leg
- ☐ Pancreatitis
- ☐ High Cholesterol
- ☐ Thyroid problem
- ☐ Bleed disorder
- ☐ Anemia
- ☐ Hemorrhoids
- ☐ Peptic Ulcer

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

VIDALIA WOMEN'S CENTER

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, his/her assistants, designees or consultants, as may be necessary in the judgment of my physician/nurse practitioner. 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, 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 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) **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