ST. MARY'S MEDICAL GROUP

Patient Registration Forms **Please Fill out Completely**

Date:	Are you a patient of any other St. Mary's Medical Group location? YES NO If yes, what other locations?	Name of Physician you are scheduled to see

Patient's Last Name	First Name	MI

Social Security Number	Date of Birth	Age	Gender	Race	Marital Status	Ethnicity (Circle one): Latino Non-Latino Other	Language

Address (Street, Route, Apt. No., etc.)	City	State	Zip Code

Home Phone	Cell Number	Cell phone carrier (ex. Verizon)

Email Address	Do any other family members use this email address? List names	Best way to contact: ☐ Home Phone ☐ Cell Phone ☐ Email ☐ Letter

EMPLOYER INFORMATION

Employed by	Occupation

Business Phone	Employer's Address	City	State	Zip Code

SPOUSE/GUARDIAN (If patient is married, give spouse information. If patient is a child, give parent information.)

Name	Relationship to patient	Responsible for bill: YES NO

Home Phone	Social Security	Date of Birth	Sex

Employed by	Business Phone

Employer's Address	City	State	Zip Code

EMERGENCY CONTACT

Name	Relationship	Home Phone	Work Phone	Mobile Phone

PHYSICIAN INFORMATION

Complete this section only if applicable

Primary Care Physician Name	Phone		
Address	**City**	**State**	**Zip Code**
Referring Physician Name	**Phone**		
Address	**City**	**State**	**Zip Code**

INSURANCE INFORMATION (Please provide your insurance card(s) at the time of visit)

Primary Insurance Name	Subscriber Name	Date of Birth	Social Security #	Relationship to patient	Responsible for bill: YES NO
Secondary Insurance Name	**Subscriber Name**	**Date of Birth**	**Social Security #**	**Relationship to patient**	**Responsible for bill:** **YES NO**

_____ _____

Patient or Guardian Signature Date

ST. MARY'S
MEDICAL GROUP

ST. MARY'S HEALTH CARE SYSTEM, INC. ("SMMG") CONSENT/AUTHORIZATIONS

CONSENT TO TREATMENT

I hereby authorize and consent to such care, examinations and treatments including, but not limited to, any medical care or treatment, examinations, diagnostic procedures, and the furnishing of such supplies in connection with or relating to treatment as are necessary or desirable in the judgment of the treating physician.

FINANCIAL AGREEMENT

I hereby assume full responsibility for all charges incurred for professional services rendered by SMMG physicians. I agree that in return for the services provided to me, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to the above mentioned medical practice for payment. If any account is sent to collections, I agree to pay collection expenses.

ASSIGNMENT OF PAYMENT OF BENEFITS

In consideration of SMMG advancing or extending credit to me for my care, I hereby assign and transfer to SMMG all benefits and payments now due and payable or to become due and payable to me under any insurance policy or policies, under any replacement policies thereof, under any self-insurance program, or under any other benefit plan. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

I request payment of authorized Medicare benefits for me, or on my behalf, for any services furnished to me by or in SMMG, including physician services.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, the undersigned, hereby authorize SMMG or their representatives to release any of my medical information, protected health information or related information pertaining to this period of treatment, including AIDS Confidential Information and psychiatric information, that may be requested by any physician, provider, hospital, healthcare facility, any insurer or third party payor with whom I have coverage, my employer, or any public agency which may be assisting in payment of my care. I authorize SMMG to release to the Social Security Administration, Department of Medical Assistance, their intermediaries or carriers, or to review organizations, any information about me as needed for this or a related Medicare, Medicaid, or Tricare claim, including medical information relating to my treatment. I understand that health care services may be subject to review by review organizations as well

I HAVE READ THE FOREGOING CONSENT TO TREATMENT, FINANCIAL AGREEMENT, ASSIGNMENT OF PAYMENT OF BENEFITS, AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION. I AM AWARE OF THE CONTENTS OF EACH AND FULLY UNDERSTAND EACH.

I ACKNOWLEDGE THAT I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES OF ST. MARY'S HEALTH CARE SYSTEM, INC.

IN WITNESS WHEREOF, I HAVE PLACED MY HAND AND AFFIXED MY SEAL AS OF THE DATE INDICATED BELOW.

_____ _____

Patient Name (Print) Patient Date of Birth

_____ _____

Patient or Guardian Signature Date

I have agreed to let certain individuals participate in discussions and decisions related to my health care. I thereby give permission for St. Mary's Medical Group, Inc. a subsidiary of ST. MARY'S HEALTH CARE SYSTEM and Doctor _____ to discuss my personal health care information with the following individual(s).

Name/Relationship _____ Phone Number _____

Name/Relationship _____ Phone Number _____

Name/Relationship _____ Phone Number _____

Conditions for Disclosure (check all that apply):

☐ The Clinic may disclose my personal health information to the individual(s) above **only** in my presence.

☐ Unless indicated otherwise, the Clinic may disclose my personal health information to the individual(s) above in my presence and when I am not physically present, including disclosures by telephone, facsimile, e-mail or regular mail.

☐ Other conditions of disclosure: _____

_____

_____

I understand that this consent may be revoked by me at any time by written notice to our office.

Patient signature: _____ Date: _____

Legal Representative: _____ Date: _____

Reason for Representative: _____

_____

FCA: 06/03

Some or all of the health care professionals performing services in this Health Care System are independent contractors and are not Health Care System agents or employees. Independent contractors are responsible for their own actions and the Health Care System shall not be liable for the acts or omissions of any such independent contractors. O.C.G.A. 51-1-29.5(d)

Consent For Disclosure to Family Member and/or Personal Representative for St. Mary's Health Care System, Inc.

Patient Name _____
Address: _____
_____
Date of Birth: _____
SSN# _____
Telephone # _____

ST. MARY'S MEDICAL GROUP

Authorization for Release of Medical Information

I authorize the use or disclosure of the below-named patient's protected health information as described below.

Patient Name		Date of Birth	Last 4 digits of SSN
Address	City	State	Zip

Please circle: I authorize St. Mary's Medical group to <u>OBTAIN or RELEASE</u> records from:
Name/Organization

Address	Phone	Fax

Please send records to:
Name/Organization

Address	Phone	Fax

If records are to be released from SMMG, please indicate which location. Check all that apply.

☐ **Athens Internal Medicine Associates**	☐ **Athens General and Colorectal Surgeons**
☐ **Community Medicine of Athens**	☐ **Clear Creek OBGYN**
☐ **Georgia Family Medicine**	☐ **Endocrine Specialists of Athens**
☐ **Johnson and Murthy Family Practice**	☐ **Infectious Disease Specialists of Athens**
☐ **Lighthouse Family Practice**	☐ **Northeast Cardiology**
☐ **Middle GA Medical Associates**	☐ **Oconee Heart and Vascular Center**
☐ **St. Mary's Internal Medicine Associates**	☐ **Rheumatology Center of Athens**
☐ **Hometown Pediatrics**	☐ **St. Mary's Neurological Specialists**

Purpose of Release? ☐ Insurance ☐ Personal ☐ Treatment Elsewhere ☐ Transfer of Care ☐ Legal
☐ Other _____

What type of records/reports should be released?

☐ Complete Record	☐ Most recent lab work	☐ Mammogram
☐ ER Record	☐ Echo	☐ CT Scan _____
☐ Office Notes	☐ Nuclear Stress Test	☐ MRI _____
☐ History and Physical	☐ Exercise Stress Test	☐ EEG
☐ Discharge Summary	☐ EKG	☐ EMG/NCS
☐ Consultation Report	☐ Carotid/Vascular Study	☐ Other:_____
☐ Surgical/Operative Report	☐ Chest X-Ray	

I understand that information in my health record may include information relating to Confidential Information and may include mental health, HIV/AIDS diagnosis, alcohol and drug use information and I also authorize the release of this information.

I understand this authorization may be revoked by me at any time. This must be in writing to the Office Manager. This would not apply to information that has already been release prior to my written revocation.

I understand that information disclosed under this authorization may be subject to re-disclosure by the recipient of such information and the information may no longer be protected under the terms of this authorization or by federal privacy laws.

I understand I may refuse to sign the authorization.

_____ **Date: _____/_____/_____**
Patient Signature/Legal Representative Signature

_____ _____
Printed Name of Legal Representative **Relationship to patient**

ST. MARY'S MEDICAL GROUP

St. Mary's Medical Group
eRx Consent

ePrescribing is a federally mandated initiative that requires all physicians to prescribe medications electronically beginning in 2011.

ePrescribing software sends your prescriptions over the internet to your pharmacy in a safe, secure way through the same technology used by credit card companies. This helps protect the privacy of your personal information.

ePrescribing software also lets your physician see important information like drug interactions and your prescription history.

The benefit to you is:

- Less confusion over handwritten prescriptions or unclear phone calls.
- Reduced possibility of medical errors.
- Less chance of adverse drug reactions.
- Fewer trips to drop off at the pharmacy.
- A safer, faster, easier way to get your prescription filled.

Patient Consent:

I agree that St. Mary's Medical Group may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

_____ _____

Patient Signature (or legal guardian) Print Patients Name

_____ _____

Primary Pharmacy Name Pharmacy Street and City

_____ _____

Secondary Pharmacy if applicable Pharmacy Street and City

_____

Date

ST. MARY'S MEDICAL GROUP

Hometown Pediatrics
1020 Jamestown Blvd, Bldg. 200, Watkinsville, GA 30677
Phone: 706-769-0005 Fax: 706-769-0403

Dear Parent/Guardian:

The physicians at Hometown Pediatrics agree strongly with the AAP recommendations that your child should receive regularly scheduled checkups which may include routine labs and testing of hearing and vision.

Insurance companies have recently changed what they will cover during a checkup. Our billing office fields many calls from parents with questions regarding their bills for charges incurred during a "checkup" that are not covered under routine well care. We have created this "checkup list" to educate families about what is routinely covered at the preventive care visits and what may result in additional charges, and ask that you sign below stating you understand and agree.

During check-ups, all children:

- Measure height, weight and head circumference (depending on age) and plot them on our growth chart.
- A body mass index (BMI) is calculated for all children older than 3 years.
- Thoroughly check body parts and systems
- Discuss age related anticipatory guidance
- Discuss safety information
- Discuss nutrition appropriate for age
- Discuss development and growth
- Discuss schooling (if age appropriate)
- Fill out forms for sports/school
- Refill Medications

Other concerns that are more complicated and involve more time or expertise such as chronic (prolonged duration) headaches, stomach pains, psychological/school problems, or other medical issues usually require a separate code and charge in addition to the check-up. We practice medicine based on the guideline from the American Academy of Pediatrics. Occasionally, some things such as bold work, other labs, prolonged discussions of topics at the time of the check up and hearing and vision testing are either not covered by your insurance or are put towards your deductible. It is up to your insurance company and specifically your medical plan as to if and how they will pay for these charges. Some plans pay 100%, others require a separate co-pay (even if there is no co-pay for checkups), and others do not cover these separate charges at all, considering it a non-covered item. **These billing issues are between you and your insurance company, and we always suggest you check with your insurer or HR department BEFORE coming to the doctor to know just what is covered and what is not by your plan.** Each plan has very different guidelines and we find even that Blue Choice for Lockheed is different from Blue Choice for Home Depot. **Please make sure you know your plan, so there are no surprises as you are responsible for payment of charges not covered by your plan.** The care we provide during these encounters is done in the interest of your child's current and future health regardless of the insurance/payment issues and we do not recommend postponing or omitting any labs, test or evaluations. Your signature below verifies that you agree to have the testing done, and know there may be an added expense for which you will be responsible.

Patient Name: _____ **DOB** _____

Parent Name: _____

Parent Signature: _____ **Date:** _____

ST. MARY'S MEDICAL GROUP

Hometown Pediatrics
Patient History Intake Form

Patient Name: _____ DOB: _____

Is the child adopted? (circle one) Yes No	If adopted, at what age?	Is child aware? (circle one) Yes No	Where was child born?	Obstetrician:

Full term pregnancy? (circle one) Yes No	If not full term, how early?	Type of delivery: (Circle one) Vaginal C-Section	Birth weight:	Birth Length:

Problems during pregnancy:	Problems during birth or in first few weeks of life?

List current medications you child is taking: ****Bring your medications with you to every visit or take a picture of the label if medication is refridgerated****

Allergic to any medications? If so, please list.	Allergic to any food or insects? If so, please list.

Has your child ever seen a specialist? (circle one) Yes No	If yes, who and reason for visit?

Has your child ever had any of the following? ☐Chicken Pox ☐Pneumonia ☐Eczema ☐Heart Problems ☐Seizures ☐Meningitis ☐Anemia ☐Urinary tract infections ☐Heart Murmur ☐Asthma/Wheezing ☐Allergies ☐Frequent Ear Infections ☐Measles ☐Frequent sinus infections ☐Developmental Delay ☐Other:

Has your child ever spent the night in the hospital? (circle one) Yes No	If yes, please list age and reason for hospitalization?
Has your child ever had any surgeries? (circle one) Yes No	If yes, please list operations and dates?

Social History:
Who lives in the home with the child? _____

Has there been a separation, divorce or death of a parent? (Circle one) Yes No If so, when? _____

Legal guardian's name: _____ Siblings Names:_____

Any smokers in the home? (Circle one) Yes No Any pets? (Circle one) Yes No If yes, what kind: _____

Family History: Please **indicate which family member has any of the following history.** Use this guide to mark appropriately. M=Mother, F=Father, MGM=Maternal Grandmother, MGF=Maternal Grandfather, PGM=Paternal Grandmother, PGF=Paternal Grandfather, B=brother, S=Sister, A=Aunt, U=Uncle ****Biological family members only****

___Birth defects/malformations
___Bleeding disorders
___Cancer
___Diabetes
___Heart attacks <60yo
___Stroke <55yo
___Asthma
___Genetic disorders
___Kidney disease
___Liver disease
___Eczema
___Thyroid disease
___Developmental Delay
___High Cholesterol
___Seizures
___High Blood pressure
___Sickle Cell Disease
___Sickle Cell trait
___Cystic Fibrosis
___Allergies
___Tuberculosis
___Celiac disease (gluten allergy)
___Mental/emotional problems
___Rheumatologic disorders
___Sudden unexpected death
___Inflammatory bowel disease