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

CONSENT AND AUTHORIZATION

DEFINITIONS

"St. Mary's" means St. Mary's Medical Group, Inc., St. Mary's Health Care System, Inc., and its affiliates. "I" or "me" or "my" means the undersigned patient or the undersigned authorized representative on behalf of the patient. "Insurance" means any policy, plan, product, network, employer benefit or plan, self-insured program, or government program or assistance applicable to the patient.

CONSENT TO TREATMENT

I authorize and consent to such assessment, care, examination and treatment (including, but not limited to, any medications, laboratory tests, imaging studies, diagnostic or other procedures, services and supplies) as St. Mary's physicians or providers may determine in their judgment to be necessary, appropriate or desirable for me (my "Care"). I understand that this consent will continue in effect unless and until I revoke it and will apply to each of my visits to any St. Mary's provider as well as to any Care which may be needed but which is not known at the time this consent is signed.

INFORMATION

I have or will provide accurate and complete information regarding my medical history including any allergies, medications, supplements, herbs and current and pre-existing conditions; and, I understand that St. Mary's and its employees, agents, staff, representatives, and contractors will rely on such information in determining and recommending the Care to be provided to me. In addition, any information I have provided regarding my eligibility for Insurance is true, accurate and complete.

STUDENTS & RESIDENTS

I understand that students, residents, interns, and fellows may from time to time be present and either observe or participate, under supervision, in my Care and I consent to their involvement in my Care.

RISKS

I understand that it is not possible to list each and every risk for every type of health care service which may occur with my Care and that there may be material risks associated with Care that will be provided to me. An additional consent form will be given to me for specific procedures such as those which involve certain types of anesthesia, amniocentesis, or injection of a contrast (dye) material. **NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME** or otherwise implied regarding the results of my Care.

FINANCIAL AGREEMENT

I understand that I am financially responsible for and obligated to pay all St. Mary's charges incurred in connection with my Care. At the time services for my Care are rendered, I will pay any applicable copayment, deductible, coinsurance, or other amount not covered by my Insurance at the time services are rendered or I will make financial arrangements satisfactory to St. Mary's for such payment. If I am uninsured or am having difficulty paying my bill(s), I understand that St. Mary's has other financial options that may be of assistance to me including free care, discounted care, and interest free payment plans, and that I should contact the St. Mary's Business Office to learn more. As permitted by the Fair Credit Reporting Act, I authorize St. Mary's to check my credit history in connection with payment for my Care. If any of my accounts is sent to collections, I agree to pay all collection expenses including attorneys' fees and court costs.

I understand some health care professionals who render Care to me may not be participating members in my Insurance and that my insurer may therefore consider such services to be non-covered. If my insurer does not reimburse for these non-participating health care professionals or non-covered services, I understand I will be responsible for any charges/balance that the insurer declines to pay.

I understand I have the option to pay for a health care service personally and not have a claim submitted to a health plan for that health care service; *however, to elect this option, I must notify the St. Mary's Business Office and must pay the bill for that health care service in full.*

ASSIGNMENT OF BENEFITS & REQUEST FOR DIRECT PAYMENT

In consideration of St. Mary's advancing or extending credit to me for the charges related to my Care, I assign and transfer to St. Mary's all rights to (and related or associated with) any and all benefits, claims and/or payments now due and payable (or to become due and payable) as reimbursement or payment for my Care under any applicable Insurance, settlement, or judgment arising out of or related to any incident which necessitated the Care, or any authorized Medicare, Medicaid, TriCare, or any other governmental benefits that may be applicable for my Care. The rights so assigned include, but are not limited to, the right to receive payment, to receive information from plans, payors or insurers as may be appropriate to determine payable benefits, and to bring claims/causes of action or file appeals on my behalf in order to obtain payment. This assignment also specifically includes the right to enforce a claim for benefits, sue for statutory penalties, assert an ERISA claim as a beneficiary of an employee benefit plan, and pursue an ERISA breach of fiduciary duty claim.

I authorize and direct that payment be made on my behalf directly to St. Mary's for my Care whether now or in the future. I authorize St. Mary's to bill my Insurance and I will use my best efforts to cooperate with and assist St. Mary's in receiving payment in full for the Care rendered to me including remitting to St. Mary's any payments I receive directly from an insurer or any source whatsoever for Care provided to me. I appoint St. Mary's Chief Financial Officer or his/her designee as my attorney-in-fact to take measures to collect the above payments and benefits and to endorse any checks payable to me related to my Care.

RELEASE OF MEDICAL INFORMATION

I authorize St. Mary's and its business associates, agents, employees, staff, representatives and contractors to release any medical or other information relating to my Care as permitted by the Health Insurance Portability and Accountability Act (HIPAA) including for payment, treatment, and healthcare operation purposes. This authorization includes information which may be protected under State law such as HIV, AIDS, mental health, substance abuse, infectious or communicable diseases, and confidential communications. I also authorize release of such information to the Social Security Administration, the Centers for Medicare and Medicaid Services, and the Department of Medical Assistance (or any of their respective intermediaries, carriers, contractors or fiscal agents), or to any review organizations, for any claim or purpose relating to my Care.

I agree my information can be shared with other past, future and current providers and facilities to coordinate my health care and for payment and administrative purposes, including quality and care management. This information may include dates and services provided, location where treatment was received, treatment information, names of doctors and health professionals, including mental health professionals, and any information related to diagnosis, hospital care, treatment, or my mental or emotional condition, except substance abuse treatment provided in a federal Part 2 substance abuse unit. I also consent to St. Mary's requesting my health information from other providers of care to me, receiving and releasing that health information, whether written, verbal, or electronic, for the uses described above as well as St. Mary's participating in the health information exchange described in the St. Mary's Notice of Privacy Practices (NPP). I acknowledge I have received the NPP and will refer to the NPP for additional, detailed information regarding the uses and disclosures of protected health information.

DISPOSAL

Any tissues or specimens removed from my body in the course of any Care may be retained by, preserved, tested and/or otherwise used by St. Mary's and its affiliates, agents, employees, staff, representatives and contractors for diagnostic, treatment, scientific and/or teaching purposes and then disposed of within their discretion and professional judgment.

INDEPENDENT CONTRACTORS

Some health care professionals performing services for St. Mary's are independent contractors and are not St. Mary's agents or employees. Independent contractors are responsible for their own actions and St. Mary's is not liable for the acts or omissions of any such independent contractors.

PHONE/E-MAIL

St. Mary's, including its business associates, may contact me by telephone at any telephone number provided by me or associated with my record, including cell phone numbers which could result in charges to me. St. Mary's may also contact me by sending text messages or e-mails using the contact information I provide. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable. By providing an e-mail address to St. Mary's, I request and consent that St. Mary's, its affiliates, agents, employees, staff, representatives and contractors use the e-mail address that I provide in addition to or in place of using U.S. Mail, fax or any other method of delivery for corresponding with me or providing me notices, reminders and other information regarding my Care, even if the communication includes my personal or health information, as applicable. I consent that emails may include communications about St. Mary's programs and services, the online Patient Portal, and fundraising for a St. Mary's affiliated foundation. I understand St. Mary's does not receive remuneration for making these communications. I may revoke this consent by contacting the St. Mary's Privacy Officer in writing, but my revocation will not be effective regarding any use or disclosure by email in reliance on this consent before St. Mary's actually receives my revocation. I acknowledge there are some risks involved in sending and receiving electronic communications including that the communications may not be encrypted and might be sent to unintended recipients. I understand I am responsible for the security of my email password. I understand not all email is necessarily confidential and I should use another method to communicate sensitive and/or urgent information.

CONSENT TO PHOTOGRAPH, VIDEOTAPE, RECORD, FILM AND AUDIOTAPE

I consent to the presence of observers during my Care as approved by my physician or St. Mary's for medical, training, scientific and/or educational purposes. I authorize my physician and St. Mary's as well as its governing bodies, officers, directors, staff, agents, contractors and employees to photograph, videotape, record, film, audiotape, and/or televise the Care and use such materials for their internal purposes including, but not limited to, patient identification, treatment, training, performance improvement, and/or educational purposes. I understand a separate consent form will be provided to me for external or commercial publication purposes.

I authorize a copy of this Consent & Authorization form to be used in place of the original.

I HAVE READ THIS FORM CAREFULLY OR HAD IT READ TO ME AND/OR EXPLAINED TO ME. I UNDERSTAND WHAT IT SAYS AND HAVE HAD ANY QUESTIONS I HAD ABOUT IT ANSWERED. I VOLUNTARILY SIGN IT ON THE DATE SET FORTH BELOW.

_____ _____

Patient Name (Print) Patient Date of Birth

_____ _____

Patient or Guardian Signature Date

ST. MARY'S MEDICAL GROUP

CONSENT FOR DISCLOSURE

I have agreed to let certain individuals participate in discussions and decisions related to my health care. I therefore give permission for the physicians, providers, and staff of St. Mary's Medical Group, Inc. (collectively, "SMMG") 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):

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

☐ Unless indicated otherwise, SMMG may disclose my personal health information to the individual(s) above in my presence as well as 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 SMMG.

Patient Signature: _____ Date: _____

Legal Representative: _____ Date: _____

Reason for Representative: _____

Consent For Disclosure to Family Member and/or Personal Representative for St. Mary's Medical Group, 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**
- ☐ **Community Internal Medicine of Athens**
- ☐ **Georgia Family Medicine**
- ☐ **Johnson and Murthy Family Practice**
- ☐ **Lighthouse Family Practice**
- ☐ **Middle GA Medical Associates**
- ☐ **St. Mary's Internal Medicine Associates**
- ☐ **Hometown Pediatrics**
- ☐ **St. Mary's Family Medicine**
- ☐ **Athens General and Colorectal Surgeons**
- ☐ **Clear Creek OBGYN**
- ☐ **Endocrine Specialists of Athens**
- ☐ **Infectious Disease Specialists of Athens**
- ☐ **St. Mary's Industrial Medicine**
- ☐ **Oconee Heart & Vascular Center**
- ☐ **Northeast Cardiology**
- ☐ **Rheumatology Center of Athens**
- ☐ **St. Mary's Neurological Specialists**
- ☐ **Georgia Neurological Surgery and Comprehensive Spine**

Purpose of Release? ☐ Insurance ☐ Personal ☐ Treatment Elsewhere ☐ Transfer of Care ☐ Legal
☐ Other (please describe) _____

What type of records/reports should be released?

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

If my health record contains information about my mental health, substance abuse, HIV/AIDS diagnosis, infectious or communicable diseases, or other sensitive or confidential information, 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; however, I understand that any revocation would not apply to information that has already been released 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 this authorization.

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

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

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)	Printed Name of Patient
_____	_____
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