Northeast Georgia PHYSICIANS GROUP

Lanier URGENT CARE

# PATIENT REGISTRATION FORM

| Date: | Reason for Visit: |
|---|---|

| LAST NAME | FIRST NAME | PREFERRED NAME | MIDDLE NAME |
|---|---|---|---|
| | | | |

| SOCIAL SECURITY # | ASSIGNED SEX AT BIRTH<br>❑ Male<br>❑ Female | I IDENTIFY MYSELF AS:<br>❑ Male ❑ Female<br>❑ Other: _____ | BIRTH DATE (mm/dd/yyyy) |
|---|---|---|---|
| | | | |

| MAILING ADDRESS | CITY | STATE | ZIP |
|---|---|---|---|
| | | | |

| HOME PHONE | WORK PHONE | MOBILE PHONE | E-MAIL ADDRESS |
|---|---|---|---|
| | | | |

| MARITAL STATUS | INTERPRETER NEEDED? | PREFERRED LANGUAGE | RACE | ETHNICITY |
|---|---|---|---|---|
| ❑ M ❑ S ❑ D ❑ W | ❑ Yes ❑ No | | ❑ Black ❑ White ❑ Asian ❑ Other | ❑ Hispanic ❑ Non-Hispanic |

| RELIGION | COMMUNICATION PREFERENCE | PRIMARY CARE PHYSICIAN |
|---|---|---|
| | ❑ Mail ❑ Phone ❑ Email ❑ Patient Portal | |

## EMPLOYER INFORMATION

| PATIENT'S EMPLOYER | OCCUPATION | WORK PHONE |
|---|---|---|
| | | |

| BUSINESS ADDRESS | CITY | STATE | ZIP |
|---|---|---|---|
| | | | |

## EMERGENCY CONTACT INFORMATION

| NAME | RELATIONSHIP | HOME PHONE | WORK PHONE | MOBILE PHONE |
|---|---|---|---|---|
| | | | | |

## GUARANTOR INFORMATION (IF PATIENT IS UNDER 18 YEARS OLD)

| GUARANTOR'S NAME | RELATIONSHIP | SOCIAL SECURITY # |
|---|---|---|
| | | |

| ADDRESS (IF DIFFERENT FROM ABOVE) | DATE OF BIRTH | SEX |
|---|---|---|
| | | |

| EMPLOYER | HOME PHONE | WORK PHONE | MOBILE PHONE |
|---|---|---|---|
| | | | |

| EMPLOYER'S ADDRESS | CITY | STATE | ZIP | NAME OF ADULT PRESENTING MINOR FOR TREATMENT | RELATIONSHIP |
|---|---|---|---|---|---|
| | | | | | |

## INSURANCE INFORMATION

| | INSURANCE COMPANY (PAYOR) | SUBSCRIBER NAME | DATE OF BIRTH | SOCIAL SECURITY # | SUBSCRIBER ID | GROUP ID | PATIENT RELATIONSHIP TO SUBSCRIBER |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| SECONDARY INSURANCE (PAYOR) | | SUBSCRIBER NAME | DATE OF BIRTH | SOCIAL SECURITY # | SUBSCRIBER ID | GROUP ID | PATIENT RELATIONSHIP TO SUBSCRIBER |
| | | | | | | | |

## INJURY/ACCIDENT INFORMATION (IF APPLICABLE)

❑ Auto/MVC ❑ Worker's Comp ❑ Other Accident:

| DATE | TIME | PLACE | NATURE |
|---|---|---|---|
| | | | |

Who may we thank for referring you to our office?

How did you hear about our office?

**PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARD(S) AND DRIVER'S LICENSE.**

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# PATIENT HEALTH HISTORY

Patient Name: _____ DOB: _____ Date: _____

**Please list all medications you are currently taking including any over-the-counter meds.**

| Medication | Dosage | Reason |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Please indicate any drug allergies.**

| | |
|---|---|
| | |
| | |

**Reason for Visit:**

**Please indicate any health conditions for which you are currently being treated or have ever been treated.**

| YES | NO | Condition | YES | NO | Condition |
|---|---|---|---|---|---|
| | | Asthma | | | High Blood Pressure |
| | | Arthritis | | | High Cholesterol |
| | | Bleeding Disorder | | | Kidney Disease |
| | | Cancer | | | Migraine |
| | | COPD | | | Musculoskeletal |
| | | Diabetes | | | Seizures |
| | | Depression/Anxiety | | | Sickle Cell Disease |
| | | Gastrointestinal | | | Sleep Disorder |
| | | Heart Disease/Heart Attack | | | Stroke |
| | | Hepatitis | | | Thyroid Disease |

**Please list any surgeries, hospitalization and/or serious injuries.**

| Reason/Type | Date | Reason/Type | Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Any chance you are pregnant? : Yes _____ No _____**

**Are you a smoker? Yes ____ No____ If yes, how many packs a day? _____**

**Do you drink alcohol? Daily____ Socially_____ Never _____**

Northeast Georgia PHYSICIANS GROUP

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# Patient Financial Responsibility

Thank you for choosing Northeast Georgia Physicians Group (NGPG) for your medical care. We appreciate that you have entrusted us with your health care, and we are committed to providing you with the best patient care possible. The following information outlines our expectations for your financial responsibility to our office.

Patients or their legal representatives are ultimately responsible for all charges for services rendered. All services rendered to minor patients will be the responsibility of the accompanying adult, custodial parent or legal guardian.

NGPG is contractually obligated to collect applicable co-payments at the time services are rendered. We are also obligated to collect any deductible and/or co-insurance amounts deemed patient responsibility by your insurance.

Uninsured (self-pay), if you do not have health insurance, we will be happy to provide care for you. We offer a discount to uninsured patients of 30% on those services that would typically be billed to an insurance company. To qualify for a 45% discount (an additional 15%), we require a minimum of $100.00 to be paid at check-in ($25.00 for pediatric patients). This payment will be applied towards any charges for your visit. If there is an overpayment, outstanding balances will be settled, and the remainder will be refunded via return to credit card or by check (depending on the method of payment for the time of service deposit).

***Procedure Deposit:*** Patients who are scheduled for a procedure may be required to pay a deposit towards their estimated patient responsibility amount. This amount would consist of any applicable copays, co-insurance, or any remaining deductible amounts. Our staff will contact your insurance company and provide you with an **estimate** of the planned procedure fee based on your plan benefits. The procedure deposit may be paid by cash, check or credit card.

You will also be contacted by hospital staff who will provide the same information for your expected hospital charges.

Please be aware that you may receive a statement from other entities such as anesthesia, lab, pathology, etc. Any questions you have regarding those charges would need to be directed to their office. NGPG does not process the billing for these services.

If you are unable to pay 100% of the estimate amount prior to your procedure, our staff will provide you with information about financing options. You will be required to make some type of payment towards your estimate amount prior to your procedure.

By signing this form, you agree that you have read and understand your financial responsibility.

Signature _____ Date _____

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# ANNUAL CONSENT / AUTHORIZATIONS

Patient Name: _____ DOB: _____

**Consent for Treatment:**

- Permission is hereby given for any medical / surgical procedures, x-rays, drug or laboratory test, medication, or exam as may be deemed necessary by the Physician, Physician Assistant, Nurse Practitioner, or Nurse Midwife.
- I understand I have the right to see a Physician if I so choose, and have the right to see a Physician prior to any prescription drug or device order being carried out by an Advanced Practitioner.
- In the case of an unemancipated minor, the consent below is being given on his or her behalf.

**Consent to Release Medical Information to a Spouse, Family Member or Significant Other:**

Tell us with whom we may discuss your protected health information: (Name and relation-Example: Jane Doe, Wife; Jan Doe, Daughter; John Doe, Partner)

1) _____ 2) _____ 3) _____

- *If you do not authorize information to be released to anyone please check this statement.*

❑ **I do not authorize any information to be released to anyone other than myself.**

**I hereby authorize messages to be left on a voice mail system or answering machine. Please indicate the number(s) NGPG staff can utilize to leave a message for you:**

1) _____ 2) _____ 3) _____

- *For Medical Records release, see form C-45.*

**Financial Responsibility:**

I understand it is the responsibility of each patient to arrange for payment for the medical services received in this office. I hereby authorize any insurance benefits to be paid directly to Northeast Georgia Physicians Group, and recognize my responsibility to pay for all non-covered services. I also authorize the release of any information necessary to process an insurance claim. Charges for all minors are the responsibility of the parent, guardian, or individual presenting the child for treatment.

I hereby authorize Northeast Georgia Physicians Group, or any of its affiliates, agents, contractors or business associates, to contact me (by any telephone numbers, email addresses or other contact points provided by me or on my behalf) by the use of any automatic dialing system, by pre-recorded forms of voice/messaging systems, by electronic mail owned or used by the guarantor/responsible party, by text messages, by telephone or by cell phone for reasons related to the services I received at Northeast Georgia Physicians Group or payment for the services I received at Northeast Georgia Physicians Group including but not limited to, debt collection purposes.

**Acknowledgment of Receipt of Nondiscriminatory Act Notice:**

☐ By initialing, I acknowledge that I received a copy of the Nondiscriminatory Act Notice.

**Acknowledgement of Privacy Rights:**

By signing below I acknowledge that I am aware of the NGHS Notice of Privacy Practices and Individual Rights. We may use or share your medical information with personnel involved in your care at the Health System. We may also disclose your medical information to people outside of the System, such as Health Information Exchanges. NGHS Notice of Privacy Practices contains more information about the policies and practices protecting the patient's privacy.

**I acknowledge that I have read the above, am giving my consent to the above, and am acknowledging I have been informed of my rights to privacy.**

**Signature:** _____ **Date:** _____

**Print Name:** _____ **Email address:** _____

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# POLICIES ACKNOWLEDGMENT

**Please read over our payment policy below and initial where required.**
**Your initials tell us that you agree to comply with these parts of the policy.**

**Payment Policy** _____ **Initials**

1. In compliance with new Federal law, we will ask you for photo identification and proof of health insurance at every visit. We may also take your picture the first time you visit our office.
2. It is not feasible for our staff be to fully aware of each health insurance plan's specific requirements or coverages. We will do everything we can to help you; however, it is your responsibility to verify that NGPG is part of your insurance plan's covered providers, and to know what your plan does and doesn't cover.
3. It is your responsibility to know what limitations your insurance plan may place on the number of times you can be seen in the office, have treatments performed, when referrals are required to receive care, or receive other types of health care.
4. Any charges you incur with us that are not paid by your health insurance according to our existing agreements will be your responsibility to pay. We will bill your insurance plan as a courtesy to you.
5. If you do not have health insurance, we will be happy to provide care for you. We offer a discount to uninsured patients of 30% on those services that would typically be billed to an insurance company. To qualify for a 45% discount (an additional 15%), we require a minimum of $100.00 to be paid at check-in ($25.00 for pediatric patients). This payment will be applied towards any charges for your visit. If there is an overpayment, outstanding balances will be settled, and the remainder will be refunded via return to credit card or by check (depending on the method of payment for the time of service deposit).
6. We will continue to provide care for you while you are paying off any outstanding balances owed. You will need to pay in full any charges you incur at the time of service while you are paying off outstanding balances. An exception may be made if your provider determines your visit is urgently needed. If you are unable to pay in full at the time of service, please ask about our payment options.
7. We do use a collection agency for accounts that fail to make a good faith effort to pay for the medical services we provide.

**Prescription Refill Policy** _____ **Initials**

Please allow 48 hours for all prescription refills. To speed up the process, please ask your pharmacy to send a refill request to the clinic.

**Medical Records Policy** _____**Initials**

We are happy to provide you with a copy of your medical records. You must first provide a properly verified signed release of information for copies provided via email, CD, or on paper. A cost may be associated depending on the number of pages requested.

**Changes in your Personal Information** _____**Initials**

You are responsible for informing us of any changes to your name, address, telephone number, email address, or health insurance coverage. A failure to do so may affect your insurance coverage and/or our ability to provide you with important information about your health.

Patient Name_____ Date of Birth:_____

Patient Signature_____ Date:_____

Parent/Legal Representative Signature:_____ Date:_____

**Northeast Georgia Health System, Inc.** **NOTICE OF PRIVACY PRACTICES** Effective Date: September 13, 2013

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS IT. REVIEW CAREFULLY.

HOW WE MAY USE AND DISCLOSE INFORMATION ABOUT YOU: The following describes different ways that we use and disclose medical information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the following categories.

**For Treatment**: We may use medical information about you for the purpose of providing medical treatment or services to doctors, nurses, technicians, medical students, volunteers, or other personnel involved in your care at the System. We may also disclose your medical information to people outside of the System who may be involved in your care such as friends or family members, if you have indicated that you would like these people to be informed of you care, or employees or medical staff members of any hospital or nursing facility if you are transferred or admitted to the facility for care.

**For Payment**: We may disclose medical information about you so that the treatment and services at the System may be billed by the System and payment collected from you, an insurance company or a third party. We may also disclose your medical information to another health care provider for payment of services you may have received at another medical facility. However, you may request that we not disclose your medical information to any persons or entities responsible for paying any portion of the charges you incur as a patient of the System provided that you pay all charges *in full* at the time of the request.

**For Health Care Operations**: We and our business associates may use and disclose medical information about you for health operations. These disclosures are necessary to run the System and ensure that all patients receive quality care. This includes disclosure of your medical information to doctors, nurses, medical students, and other personnel at the System for review and learning purposes. We may also disclose your information to researchers collecting medical information to study health care and health care delivery—we will remove information that personally identifies you before providing researchers with your information. Disclosures may also include other providers for use in their healthcare operations.

**Health-Related Benefits and Services**: You will not receive any marketing or advertising communications from us unless you indicate in your signed (or acknowledged) Notice of Privacy Practices that you wish to receive such communications. If you indicate that you would like to receive such communications, we may use or disclose your medical information to inform you of benefits or services that may interest you. If at any time you decide that you no longer wish to receive such communications, you may elect not to receive further marketing or advertising communications by contacting the number provided or by notifying the System's Privacy Office in writing.

**Sale of Health Information**: We will not sell your health information unless you have authorized us to do so in your signed Notice of Privacy Practices.

**Fundraising Activities**: We may use your medical information to contact you about our efforts to raise money. You may opt out by providing your written request to the System's Privacy Office or by informing the individual who contacts you of your desire to opt out of fundraising communications. Each time we contact you regarding fundraising efforts, we must ask you if you wish to opt out of all future fundraising communications.

**Hospital Directory**: We may include limited information about you in the hospital directory while you are a patient at the System. If you do not want anyone to know this information or to limit the amount of information that is disclosed and to whom, you may request limitations at the time of registration or during your stay.

**Special Situations**: In the following special situations we may release your medical information: organ and tissue donation, active duty military personnel and veterans, workers compensation, public health activities, health oversight activities, lawsuits and disputes, law enforcement, coroners and medical examiners, national security and intelligence activities, protective services for the President and others, inmates, and research, public health threat and safety of others, disaster relief efforts.

***Psychotherapy Notes***: Psychotherapy notes will not be disclosed outside of the System except as authorized by you in writing, pursuant to court, or as required by law. Notes will only be disclosed to personnel at the System who wrote the notes (except for training purposes and to defend against a legal action brought against the entity) unless you properly authorized such disclosure in writing.

## YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

**OUR OBLIGATION TO YOU**: (1) To make sure that medical information that identifies you is kept private; (2) To notify you regarding our legal duties, your legal rights, and our privacy practices at the System; (3) To abide by these terms of notice. You have the following rights regarding medical information we maintain about you:

**Right to Inspect and Copy**: You have a right to inspect and receive a copy of your medical record. If your request is denied you may request that the denial be reviewed, and that decision will be final. You may be charged a fee for the costs associated with copying, mailing, or other supplies associated with the request. If all or any portion of your health information is in an electronic format, you may request an electronic copy.

**Right to Amend**: If you feel that the medical information about you in your record is incorrect or incomplete, you may ask us to amend it. To request an amendment, your request must be made in writing and submitted to the System's Health Information Management department. If your request is denied, you may submit in writing a statement of disagreement and ask that it be included in your medical record.

**Right to an Accounting of Disclosures**: You have a right to request a list of certain disclosures that we have made regarding your medical information. To request this you must submit your request in writing to the System's Privacy Office.

**Right to Request Restrictions**: You have a right to request a restriction or limitation on the medical information we use or disclose about you, except where disclosure of the information is required by law. To request restrictions, you must make your request in writing to the System's Privacy Office. ***We are not required to agree to your request***. If we do agree, we will comply with your request except where the information is needed to provide you with emergency treatment.

**Right to Request Confidential Communications**: You have a right to request that we communicate with you about medical matters in a certain way and at a certain location. To request confidential communications, make your request at the time of registration or during your visit.

**Right to this Notice**: You have a right to a paper copy and may request it at the time of service or by contacting the System's Privacy Office.

**Changes to this Notice**: We reserve the right to change this notice. We will post a copy of the current notice. The notice will contain the effective date in the top right corner. If the notice changes, a copy will be available to you upon request.

**INVESTIGATIONS OF BREACH**: If we determine that the disclosure of your medical information constitutes a breach of the federal privacy or security regulations governing unsecured protected health information, we will (1) Provide a notice of the breach (2) Advise you of what we plan to do to mitigate the damage (if any) caused by the breach and (3) Advise on steps you should take to protect yourself from potential harm from the breach.

**ADDITIONAL INFORMATION:** If you would like more information, contact the System's Privacy Office at 770-219-5403.

**COMPLAINTS**: If you believe your privacy rights have been violated, you may file a complaint with the System or with the Secretary of the United States Department of Health and Human Services. To file a complaint with the System, contact the System's Privacy Office by mail at 743 Spring Street, Gainesville, Georgia 30501, or call 770-219-5403. **You will not be penalized for filing a complaint**.

**OTHER USES OF MEDICAL INFORMATION:** Other uses and disclosure of medical information not covered by this notice may be made in accordance with your written permission or as required by law. If you provide us with permission to use or disclose your medical information, you may revoke that permission at any time. To revoke your permission, you must provide your request in writing to the System's Privacy Office.

# DISCRIMINATION IS AGAINST THE LAW

Northeast Georgia Health System, Inc. (NGHS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. NGHS does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

NGHS:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

Qualified sign language interpreters

Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

Qualified interpreters

Information written in other languages

If you need these services, contact:

**NGHS' Customer Care Resource Center**
**Telephone Number:** 770-219-2998.

If you believe that NGHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

**NGHS Corporate Compliance**
743 Spring Street NE
Gainesville, GA 30501

**Telephone Number:** 770-219-5403, (TTY: 1-800-255-0135) (VRS: 1-888-888-1116)

**Fax:** 770-219-2910, or **Email:** corporate.compliance@nghs.com.

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, NGHS Corporate Compliance is available to help you.

You can also file a civil rights complaint with the U. S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

**U.S. Department of Health and Human Services**
200 Independence Avenue, SW
Washington, D.C. 20201

**Phone:** 1-800-868-1019

**TDD:** 1-800-537-7697

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.