Georgia Internal Medicine Partners, LLC.

Patient Registration Information

atient's Personal Information

ame: _____ SS#: ____ - ____ - _____ DL#: _____

Marital Status: S / M / D / W Date of Birth: __ / __ / ____ Sex: M / F

ace:_____ Ethnic Group:_____ Primary Language:_____

Main phone#(___)_____ Alternate phone: (___)_____E-mail:_____

ddress: _____ Apt#: _____

ity: _____ State:_____ Zip:_____

mployer:_____ Occupation:_____

Work phone: (___)_____ Employer Address:_____

Emergency Contact:

Name:_____ Relationship:_____Phone #:_____

Guarantor Information Relationship to patient: ☐Self ☐Spouse ☐Father ☐Mother ☐Other_____

Name: _____ SS#: ____ - ____ - _____ DL#: _____

Date of Birth: ___ / ___ / ____ Main phone#: (___)_____ Alternate phone: (___)_____

Address: _____ Apt#: _____ City: _____ State:_____ Zip:_____

Employer:_____ Work phone: (___)_____

Patient's Insurance Information

Primary Insurance Company Name:_____ID#:_____

Group#: _____ Insurance Address: _____

Subscriber Name: _____ Date of Birth: ___ / ___ / ____

Subscriber's relationship to patient: ☐Self ☐Spouse ☐Father ☐Mother ☐Other_____ Copay: $_____

Secondary Insurance Company Name:_____ID#:_____

Group#: _____ Insurance Address: _____

Subscriber Name: _____ Date of Birth: ___ / ___ / ____

Subscriber's relationship to patient: ☐Self ☐Spouse ☐Father ☐Mother ☐Other_____ Copay: $_____

ALL MEDICARE PATIENTS MUST COMPLETE THIS SECTION

Are you receiving Black Lung Benefits? Yes _____ No _____

Are the services to be paid by a government research program? Yes _____ No _____

Are you entitled to benefits through the Department of Veterans Affairs? Yes _____ No_____

Was the illness/injury due to work-related accident/condition? Yes _____ No _____

Was the illness/injury due to a non-work related accident? Yes_____ No _____

Are you entitled to Medicare based on age? Yes_____ No _____

Are you entitled to Medicare based on End-Staged Renal Disease? Yes _____ No _____

I request that payment of authorized insurance benefits be made on my behalf to the provider indicated above for services furnished me. I authorize any holder of medical information about me or my dependent to release to the insurance company any information needed to determine these benefits or the benefits payable for related services. A photocopy of this assignment is to be considered as the original. I understand that I am financially responsible for all charges whether or not covered by said insurance. This assignment will remain in effect until revoked by me in writing. I further agree to pay the cost of collection, court costs, and other reasonable fees should they be required in the event of my non-payment. (If this patient is a minor child, the parent signing this form will be financially responsible for the child. Any legal agreement, or other disagreement, between parents in a divorce must be dealt with between those parties and does not involve Georgia Internal Medicine Partners, LLC. Patient Signature:_____

Date:_____

Georgia Internal Medicine Partners, LLC

1203 George C. Wilson Drive Suite B
Augusta GA. 30909
Phone (706)447-1118 Fax (706)826-2775

Notice of Privacy Practices [short form]

his Notice Describes How Medical Information about You May Be Used and Disclosed and How You Can Get Access to This Information. Please Review It Carefully.

We May Use and Disclose Medical Information About You. The following categories describe different ways that we use and disclose :al information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you st. 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 ithin one of the categories. **For Payment**: We may use and disclose medical information about you so that the treatment and services you ve at Georgia Internal Medicine may be billed to and payment may be collected from you, and insurance company, or a third party. For ıple: we may disclose your record to an insurance company, so that we can get paid for treating you.
Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical mation about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at Georgia nal Medicine or the hospital. For example, we may disclose medical information about you to people outside Georgia Internal Medicine may be involved in your medical care, such as a family member, clergy or other persons that are part of your care.
Health Care Operations: We may use and disclose medical information about you for health care operations. These uses and disclosures ıecessary to run Georgia Internal Medicine and ensure that all of our patients receive quality improvement efforts. WHO WILL FOLLOW S NOTICE? This notice describes Georgia Internal Medicine policies and procedures and that of any health care professional authorized to r information into you medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and er Georgia Internal Medicine personnel. POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION: We create a ord of the care and services you receive at Georgia Internal Medicine. We need this record in order to provide you with quality care and to nply with certain legal requirements. This notice applies to all of the records of your care generated by Georgia Internal Medicine, whether de by Georgia Internal Medicine personnel or by your personal doctor. The law requires us to: make sure that medical information that ntifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: pointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your re; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal formation could include disclosure to, or for; coroners, medical examiners and funeral directors; health oversight activities; inmates; law vorcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective rvices for the President and others; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

ou have the following rights regarding medical information we maintain about you: **Right to Paper Copy of this Notice**: You have the right) a paper copy of this notice. You may ask us to give you a copy of this notice at any time. **Right to Inspect and Copy**: You have the right to ıspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in ertain very limited circumstances. **Right to Amend**: If you feel that medical information we have about you is incorrect or incomplete, you nay ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, Georgia nternal Medicine. To request an amendment, your request must be made in writing and submitted to Medical Records and you must provide a eason that supports your request. We may deny your request for an amendment. **Right to Request Restrictions**: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also nave the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend. *We are not required to agree to your request.* If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restriction, you must make you request in writing to medical records. **Right to Request Confidential Communications**: You have the right to request that we communicate with you about medical matters in a certain way or a certain location. You must make your request in writing and you must specify how or where you wish to be contacted. **Right to an Accounting of Disclosures:** You have the right to request and accounting of disclosures. This is a list of the disclosures we made of medical information about you. Records must be made to medical records in writing. **CHANGES TO THIS NOTICE**: We reserve the right to change this notice. We will post a copy of the current notice in the waiting room. **COMPLAINTS**: If you believe your privacy rights have been violated, you may file a complaint with our office at (706) 447-1118 or with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint. All complaints must be submitted in writing. **OTHER USES OF MEDICAL INFORMATION**: Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. Any permission can be revoked at any time as long as they are submitted in writing.

I acknowledge by signing below that I have received the Notice of Privacy Centers and Notice of Individual Rights.

Patient Name (Printed) _____ Patient or Patient's Representative (Signature) _____ Date _____

Georgia Internal Medicine Partners, LLC

James L. Millen, MD, CDE
Lamar B. Peacock, MD

DIPLOMATE
American Board of Internal Medicine

Patient Name: _____ Date of Birth: _____

Consent

I hereby authorize and concede to examinations and treatments, as well as the release of medical information to my insurance companies, claim representatives, adjustor, and other physicians by Georgia Internal Medicine. I understand that my demographic information is stored in the Allscripts Data Repository.

I acknowledge by signing below that the Notice of Privacy Practices (HIPAA) and notice of Individual Rights are posted and that I have read, or have had the opportunity to read, and understand the notice. I understand that I can rescind my privacy choices at any time.

Appointment Reminders and Lab Results

As a service to our patients, we routinely phone your home to remind you of your upcoming appointment and to call with lab results or test results.

We need to know:

A) May we contact you in this manner to remind you of your appointment or results?

☐ Yes ☐ No

B) If there is no answer, may we leave this information on your answering machine?

☐ Yes ☐ No

C) If you are not available, may we leave this information with the person answering the phone?

☐ Yes ☐ No

Discussion of Your Protected Health Information

By law, we are not allowed to discuss your protected health information with anyone else. Is there anyone with whom we may discuss your protected health information?

Yes, you may discuss my protected health information with the following people:

_____ _____

_____ _____

_____ _____

NAME RELATION

If you choose for your information not to be discussed with anyone, please just write NO ONE on one of the lines above.

_____

Patient/Responsible Party Signature _____ Date _____

Georgia Internal Medicine Partners, LLC

James L. Millen, MD, CDE
Lamar B. Peacock, MD

DIPLOMATE
American Board of Internal Medicine

Authorization to Release Medical Records

Name _____ _____ _____
Last First MI

Address _____ _____ _____ _____
Street or PO Box City State Zip

Phone _____ Date of Birth _____

I authorize _____ to release medical information from my
Physician or Hospital Name and Phone #

medical record to:

Georgia Internal Medicine Partners, LLC
James L. Millen, MD - Lamar B. Peacock, MD
1203 George C. Wilson Drive, Suite B
Augusta, GA 30909
Phone: 706-447-1118 – Fax: 706-826-2775

For the purpose of review/examination. I further authorize you to provide such copies there of as may be requested. The foregoing is subject to such limitations as indicated below:

□ Entire Record

□ Specific Information: _____

□ Old records from previous physicians: _____

This authorization will automatically expire one year from the date signed. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon.

Signature _____ Date _____

Witness _____ Date _____

[Type text]

Georgia Internal Medicine Partners, LLC.
FINANCIAL POLICY

Thank you for choosing Georgia Internal Medicine to serve you and your health needs. We are pleased to participate in your health care and look forward to establishing a lasting relationship as your health care provider. As part of this relationship, we wish to establish our expectations of your financial responsibility as outlined in our Financial Policy. Your medical insurance is a contract between you and your insurance company. We can often help with providing information to help you in filing claims, but you are primarily responsible for any charges that you have incurred as a patient with Georgia Internal Medicine. Please review and sign the following financial policy prior to your office visit.

1) CO-PAYMENTS AND PATIENT BALANCES – All co-payments and outstanding patient balances are due at the time of your appointment. ALL co-pays must be paid BEFORE your visit. We accept cash, check, or credit cards.

2) INSURANCE – If you have insurance that we participate with, we will file your claim. Patients must complete and sign information and insurance forms prior to seeing the physician. You must present a current insurance card at each visit. If you or your children do not present a current insurance card, you will be responsible for payment at the time of your visit. If your insurance carrier is not one with which we participate, you are responsible for payment in full. Insurance plans consider some services to be "**non-covered**," in which case you are responsible for payment in **FULL**. If your insurance company has not paid a claim on your behalf with 90 days because of information that you have not provided, the balance will be transferred to your account and you will be responsible for payment. If we receive payment at a later date, you will be reimbursed by our office.

3) MINORS AND DEPENDANTS – Parents and guardians are responsible for payments for their dependants at the time the service is rendered. Minors and dependants must present a valid insurance card at each visit if a claim is to be filed. See item #2 above if an insurance card is not presented.

4) MISSED APPOINTMENTS – Unless they are cancelled at least 24 hours in advance, our policy is to charge for missed appointments. The fee for a missed appointment is $25. This fee is not covered by your insurance plan and is your responsibility.

5) PROMPT PAYMENT – Just as we make every effort to accommodate you when you are in need of medical care, we expect that you will make every effort to pay your bill promptly. If you have a financial hardship or if you are unable to pay your bill in its entirety please contact our billing office to discuss payment options. If your account becomes delinquent and you have not established or met payment options with our billing office, your account will be turned over to a collection agency and we will ask you to seek your medical care from another medical office. **Patients will be responsible for any charges incurred by a collection agency and/or court fees.**

I, _____, have read the above financial policy and agree to all of its terms.
Printed Name

_____ _____
Responsible Party Signature Date Signed

Georgia Internal Medicine Partners, LLC

James L. Millen, MD, CDE
Lamar B. Peacock, MD

DIPLOMATE
American Board of Internal Medicine

Nurse Intake Sheet

Name: _____
Last First MI

Home # _____ Cell # _____ Work # _____

DOB _____ Age: _____ SSN: _____

Occupation: _____ Marital Status: _____ Live Alone? _____

Who referred you to us? _____

What is your main complaint or symptom at this time? _____

How long has this been a problem? _____

Please check the symptoms that you currently have related to this problem:

- ○ Fever: How high/how long present? _____
- ○ Tiredness : Describe _____
- ○ Weight loss: How much, what period of time? _____
- ○ Headaches: Describe _____
- ○ Blood in stool, Black stool: Describe _____
- ○ Vision Problems: Describe _____
- ○ Shortness of Breath: When and unusual aspects? _____
- ○ Chest Pain: Describe _____
- ○ Palpitations: Describe _____
- ○ Nausea & vomiting: Describe _____
- ○ Diarrhea: How often? _____
- ○ Depression: How long? _____
- ○ Sleep problems: How long and describe _____
- ○ Swelling in legs: Any association with breathing problems? _____
- ○ Problems with urination: Pain or difficulty? _____

Females Only:

- ○ Menstrual problems — Pregnancies- Number ____
- ○ Pregnant — Children- Number ____

Check if applicable:

- ○ Blood transfusion
- ○ High risk of AIDS infection

Doctor's previously seen and the reasons for seeing them: _____

_____

Operations and surgeries with dates: _____

_____

Medical Problems (e.g. thyroid, diabetes, heart disease, etc.): _____

_____

Current Medications: _____

_____

Medication Allergies: _____

Family History

Mother: _____

Father: _____

Any other relevant family history? _____

_____

Do you smoke? ____ If yes, how many years, and how many per day? _____

If relevant, what year did you quit? _____

Alcohol (social, never, on occasion, every day, etc.): _____

Any other helpful information that may be useful to the doctor? _____

_____

Pharmacy you want medications called/sent to: _____

♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦FOR OFFICE USE ONLY♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦♦

Weight _____ Height _____ BP_____ P_____

MEDICATION LIST

MEDICINE NAME	DOSE	REASON TO TAKE	DATE STARTED	DOCTOR / PHARMACY	WHEN TO TAKE