

FAMILY PRACTICE CENTER

Year: 2012

Patient's Legal Name: _____ What do you want to be called: _____
First Last MI

Address: _____
Street City State Zip

County: _____ Cell Phone: _____ Date of Birth: _____ Sex: _____

Marital Status: (Circle) Single Married Divorced Widowed Separated Other: _____

Referred by: _____ Address _____ Home Phone _____

Occupation _____ Employer or School _____ SS# _____

Employer or School Address _____

Employer Phone _____ Ext#(if any) Full Time _____ Part-time _____

Financially responsible Party (If not Patient) _____

Address if Different _____

Home Phone _____ Birth Date _____ Sex _____ Relationship _____

Their Employer _____ Work Phone _____ SS# _____

Insurance Primary Insurance, other, if any
Policy Holder: _____
Self or Name and Relationship Self or Name and Relationship

Insured ID# _____

Group Name _____

Medicare Number _____ (Indicate if Non-employer Group or Individual Policy)

Nearest Relative Not Living With You: _____

Name Relationship
Their Phone # _____ Address _____

Release: I hereby authorize the release to my insurance company or appropriate medical personnel any information required to process my insurance claim(s) regarding services and treatments provided.

Signature: _____ Date: _____
Patient Responsible Party

Assignment: I hereby authorize the payment of medical benefits for services rendered directly to Family Practice Center. I further agree that should the amount paid by my insurance company be insufficient to cover the entire amount of the charges, I will be responsible for the remaining balance.

Signature _____ Date: _____
Patient Responsible Party

CANCELLATION POLICY: I understand that if I do not cancel scheduled appointments within 24 hours prior to the appointment time, I will be charged \$35.00 for the missed appointment and \$75.00 for a missed physical exam appointment.

Signature: _____ Date: _____
Patient Responsible Party

NON-PAYMENT POLICY: I understand that if I do not pay my Co-pay, Co-insurance, Deductible or Private Pay at the time of service, I will be charged a \$35.00 billing fee in addition to my co-pay.

Signature: _____ Date: _____
Patient Responsible Party

PATIENT QUESTIONNAIRE

Name: _____ Date: _____

INSTRUCTIONS: This questionnaire will help your doctor better understand problems that you may have. Your doctor may ask you more questions about some of these terms. Please make sure to check a box for every item.

During the PAST MONTH, have you OFTEN been bothered by ...

- | | Yes | No | | Yes | No |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Stomach Pain | <input type="checkbox"/> | <input type="checkbox"/> | 19. Your eating being out of control | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Back pain | <input type="checkbox"/> | <input type="checkbox"/> | 20. Little interest or pleasure in doing things | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Pain in your arms, legs, or joints. | <input type="checkbox"/> | <input type="checkbox"/> | 21. Feeling down, depressed or hopeless | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Menstrual pain/problems | <input type="checkbox"/> | <input type="checkbox"/> | 22. Nerves, or feeling anxious or on edge | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Irregular periods | <input type="checkbox"/> | <input type="checkbox"/> | 23. Worrying about a lot of different things | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Pain or problems during sexual intercourse | <input type="checkbox"/> | <input type="checkbox"/> | 24. Have you had an anxiety attack, unreasonable feeling of fear or panic | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Headaches | <input type="checkbox"/> | <input type="checkbox"/> | 25. Have you thought you should cut down on your drinking of alcohol. | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Chest pain | <input type="checkbox"/> | <input type="checkbox"/> | 26. Has anyone complained about your drinking | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Dizziness | <input type="checkbox"/> | <input type="checkbox"/> | 27. Have you felt guilty or upset about your drinking. | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Fainting Spells | <input type="checkbox"/> | <input type="checkbox"/> | 28. Was there ever a single day in which you had five or more drinks of beer, wine or liquor. | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Feeling your heart pound or race. | <input type="checkbox"/> | <input type="checkbox"/> | 29. Overall, would you say your health is: | | |
| 12. Shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | Excellent |
| 13. Constipation, loose bowels or diarrhea | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | Very Good |
| 14. Need to get up at night to urinate regularly. | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | Good |
| 15. Nausea, gas or indigestion. | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | Fair |
| 16. Feeling tired or low energy | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | Poor |
| 17. Trouble sleeping | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 18. The thought that you have a serious, undiagnosed disease | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Other pertinent health information:

CHECK PAST ILLNESSES:	AGE	AGE	AGE
Chickenpox	_____	Pneumonia	_____
Back Pain	_____	Bronchitis	_____
Arthritis	_____	Pleurisy	_____
Healing Loss	_____	High Cholesterol	_____
Emphysema	_____	Diabetes	_____
Rheumatic Fever	_____	Ulcer	_____
Hay Fever	_____	Hepatitis	_____
Gout	_____	Heartburn/Reflux	_____
			Mononucleosis _____
			Venereal Disease _____
			Shortness of Breath _____
			Heart Attack _____
			Kidney Trouble _____
			Stroke _____
			High Blood Pressure _____
			Benign Prostate Hypertrophy _____

Operations:(Age)_____

Serious injuries(broken bones, knocked unconscious, etc.): (Age)_____

Serious illnesses or hospitalization (Tuberculosis, kidney stones, etc.):_____

Pregnancies (any serious complications) (Age)_____

Last Pap:_____ Mammogram:_____ Contraception(Type _____ If pill, name pill_____

Immunizations: (Date) Last TB test_____ Tetanus_____ MMR_____ HepatitisB _____

Recent medications and dosages (include laxatives, antacids, aspirin):_____

Allergies (medications, pollens, foods, etc.):_____

Sleep (how much, sound or fitful?)_____

Diet: Is it well balanced_____

Tobacco: Packs/Day_____ #of Years_____ Alcohol (drinks per day)_____ Coffee (cups per day) Reg/Decaf_____

Have you ever smoked?_____ How long_____ Have you ever tried to stop smoking_____

Birthplace: States where you have resided and Foreign Travel?_____

Education (Highest level completed; special studies)_____

Type of exercise and hobbies:_____

Special problems related to home or work conditions:_____

Check if anyone in your family has ever had the following:

	Relationship		Relationship		Relationship
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Stroke	_____	<input type="checkbox"/> Gout	_____
<input type="checkbox"/> High Blood Pressure	_____	<input type="checkbox"/> Migraine Headaches	_____	<input type="checkbox"/> Hay Fever or Asthma	_____
<input type="checkbox"/> Anemia	_____	<input type="checkbox"/> Obesity	_____	<input type="checkbox"/> Arthritis	_____
<input type="checkbox"/> Heart Disease	_____	<input type="checkbox"/> Thyroid Disease	_____	<input type="checkbox"/> Mental Illness	_____
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Elevated Cholesterol	_____	<input type="checkbox"/> Allergies	_____
<input type="checkbox"/> Bleeding Disorder	_____	<input type="checkbox"/> Kidney Disorder	_____	<input type="checkbox"/> Other	_____

	IF LIVING	IF DECEASED		IF LIVING	IF DECEASED
	Age	State of Health	Age	State of Health	Age
Mother	_____	_____	_____	_____	_____
Father	_____	_____	_____	_____	_____
Brothers	_____	_____	_____	_____	_____
			Sisters	_____	_____
			Husband/wife	_____	_____
			Children	_____	_____

If you need more space, use back side:

Name:_____ Date:_____

RIGHTS AND RESPONSIBILITIES

YOU HAVE A RIGHT:

- To be treated with respect, consideration and dignity at all times.
- To receive assistance in a responsible manner
- To receive information about your health including your diagnosis, treatment, testing or procedures and medical alternatives including associated risks that may be involved in your healthcare.
- To know the identity and professional status of individuals providing services to you.
- To expect that your medical records and communications will be treated in a confidential manner.
- To refuse treatment and be advised of the alternative and likely consequences of your decision.
- To express a complaint to the Administrator, and/or Physician.

YOU HAVE A RESPONSIBILITY:

- To review and understand your health insurance coverage and benefits.
- To learn and understand the proper use of your insurance plan services and procedures for obtaining coverage. This includes knowing the referral policy for your plan, laboratory restrictions and outpatient facilities covered by your plan as well as co-pay requirements.
- To always carry your insurance plan identification card and be prepared to show it at each visit, if asked. Patients will be required to pay for all services provided if insurance information is not provided by the patient at the time services are rendered or the information provided is inaccurate.
- To treat all office personnel respectfully and courteously.
- To keep scheduled appointments and to notify the office promptly if you will be delayed or unable to keep an appointment.
- To pay all charges for co-payments, deductibles, non-covered benefits or services at the time of your visit, unless prior arrangements have been made.
- To ask questions and seek clarification until you fully understand the care you are receiving.
- To follow the advice of your medical provider and consider the alternatives and/or likely consequences if you refuse to comply.
- To provide honest and complete information to those providing medical care.
- To express your opinions, concerns, or complaints in a constructive and appropriate manner.

I have read and understand the office policy as stated above:

Patient _____ Date: _____

James H. Wheeler, M. D.

C. Steven Schramm, M. D.

FAMILY PRACTICE CENTER

Patient Consent for Use and Disclosure of Protected Health Information

With your consent, Family Practice Center, P.C. may use and disclose protected health information (PHI) about you to carry out treatment, payment and health care operations (TPO). Please refer to our Notice of Privacy Practices for a more complete description for such uses and disclosures. You have the right to review our Notice of Privacy Practices prior to signing this contract. We reserve the right to revise our Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our Privacy Officer at 993-F Johnson Ferry Road, Suite 210, Atlanta, Ga. 30342.

With your consent, Family Practice Center, P.C. may call your home or office and leave a message in reference to any items that assist the practice in carrying our TP such as appointment reminders, insurance items and any call pertaining to your clinical care.

Choose your preference: Home Cell Office

With your consent, Family Practice Center, P.D. may mail to your home or office any item that assists the practice in carrying out TPO such as appointment reminder cards and patient statements.

You have the right to request that we restrict how we use or disclose your PHI to carry out treatment, payment and health care operations. However, we are not required to agree to your requested restrictions, but if we do, we are bound by our agreement.

By signing this form, you are consenting to our use and disclosure of your PHI to carry out treatment, payment and health care operations. This consent may be revoked in writing except to the extent that we may have already made disclosures in reliance upon your prior consent. If you decline to sign this consent, we may decline to provide treatment for you.

Signature of Patient or Legal Guardian _____

Patient's Name _____ Date _____

Print Name of Patient or Legal Guardian _____

**FAMILY PRACTICE CENTER, PC
ADMINISTRATIVE SERVICES AVAILABLE**

Chargeable items you will pay for on an “as requested” basis include, but is not limited to:

Completion of all patient requested forms, to include, but not limited to letters or any information requiring a physician’s signature, which includes other miscellaneous or administrative forms required by third parties other than you insurance company. **EACH FORM WILL COST YOU \$60.00.**

Examples of forms patient request us to complete on their behalf:

1. Prior authorization for approval of prescription medications when needed.
2. Foreign Travel Forms
3. Adoption Forms
4. Camp Forms
5. School Forms
6. Family Medical Leave Act (FMLA), disability forms, life insurance forms.
7. Sports physical forms
8. Other miscellaneous administrative forms required by third parties other than your insurance company.
9. Prescription pre-certifications.

- Patients who request computer generated reports (extra claims, statements, payment histories, etc) may be charged \$20.00 per each request. Out Patients tend to request these computer reports for flex benefit plans and/or yearly tax needs.
- Other administrative services that are not a covered service/benefit under your certificate of insurance. Fee to be determined at time of request.
- Patient requests for copying of medical records: \$35.00 per request. All Medical Records must be in writing and received in our office one business week prior to the date that records are needed. Records over 10 pages will be mailed, not faxed.

REMEMBER, if you choose not to pay the ASF fee today, you will be charged for the administrative services when you request them. Each form you request us to complete will require us to collect \$60.00 per form. **You will not be given a chance to pay the ASF at the time you request a form to be filled out.**

We are committed to providing you the best possible care. With you, our patient, we look forward to a lasting and healthy relationship. Thank you for your understanding and cooperation.

FAMILY PRACTICE CENTER PATIENTS

Providers prescribe the appropriate amount of medications and number of refills at each visit to ensure each patient has sufficient quantities until their next visit. **Therefore, you will need to make an appointment for an office visit to get most medications refilled.**

All prescription questions must be called in before 1:00 pm. to be answered the same day. Calls received after 1:00 p.m. may be returned the following day.

**FAMILY PRACTICE CENTER, INC.
FINANCIAL POLICY and
ADMINISTRATIVE SERVICES FEE**

Patient Name: _____
(Please print)

We are committed to meeting your healthcare needs. Our goal is to keep your insurance and financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner, we ask you adhere to the following guidelines and choose a plan that meets your needs.:

1. It is your responsibility to provide us with your current address, telephone number and insurance information at each visit.
2. It is your responsibility to contact your insurance carrier to confirm that our physicians participate in your plan. If you see a doctor that is not currently on your plan, you will be responsible for payment in full.
3. All copayments are due at the time of service. A \$35 service fee will be charged for failure to pay the copayment at the time of service.
4. You are ultimately responsible for payment for services you receive from our office. Any check payment dishonored by your bank will result in a \$35 returned check charge being added to your account.
5. If you miss your appointment, you may be charged a NO-SHOW fee of \$35 for each appointment missed. You will be charged a \$75 NO-SHOW fee for missing a complete physical

Our office collects an Administrative Service Fee of (a) \$5 on each visit or (b) an annual, optional fee of \$60.00. These administrative fees are intended to cover the cost of certain administrative services we may provide that are not covered by your insurance. You are not required to pay the Administrative Service Fee; however, if you choose not to pay the optional fee, you will be charged for all administrative services, as needed. A list of our administrative services with associated fees is attached to this Financial Policy.

- I accept the financial policy that includes payment of the Administrative Services fee.
..... \$5.00 per visit
..... \$60.00 annually
- I accept the financial policy, but choose NOT to pay the Administrative Service Fee (ASF). I understand the services listed on the next page are included in the ASF. I understand that, if I elect not to pay the ASF, I will pay for the services as I need them.

Patient Signature _____ Date _____

TO: All HMO and POS Policy Holders

RE: Guidelines for obtaining a written referral

Effective: January 1, 2009

Our office will no longer accept referral requests on the day of or after an appointment. You must contact your Primary Care Provider (PCP) before scheduling an appointment with a specialist.

All HMO Plans and select POS plans require written referrals. Your PCP is the only entity authorized to provide you with this document.

If you fail to contact us prior to making your appointment, you may be responsible for any and all expenses charged by the specialist to your insurance company. You can contact your insurance company for a listing of specialists in your network that require a written a referral. If you have not been seen within six months of your last office visit, you will need to schedule an appointment to obtain your referral.

Please wait until you have received your referral, by mail, before scheduling your appointment. Referral requests will be completed within 72 hours of receipt.

Thank you for your cooperation.

Respectfully,

Referral Coordinator

I have read the above statement regarding written referrals, with comprehension, and agree to adhere to these guidelines.

Signature

Date