FAMILY HEALTH CARE CENTER

23702 US Highway 80 East, Statesboro, GA 30461

PH: (912) 489-4090 Fax: (912) 764-5028

PATIENT REGISTRATION FORM

Patient Information

Patient Last Name_____ First_____ MI_____ Date of Birth_____

Social Security No._____ Sex: Male ____ Female ____ Race_____ Hispanic, Latino, Spanish: Y / N

Mailing Address _____

City/State/Zip_____ Primary Phone _____ Cell / Home

Secondary Phone_____ Email Address_____

Responsible Parent Information if Patient is Under Age of 18

Parent's Name (Last, First, Middle) _____ Parent's Date of Birth _____

Preferred Pharmacy _____ Phone No. _____ Fax No. _____

Referred By: Dr. _____ Family _____ Friend _____ Other _____

Insurance Information

Policy #_____ Insurance Name_____

Subscriber/Policy Holder's Name_____ Subscriber DOB_____

The policy is under: (Circle One) Patient Spouse Parent Other

Secondary Insurance _____ Policy #_____

In Case of EMERGENCY

Name of local friend or relative (not living at same address)

_____ Relationship to Patient_____Phone#_____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am responsible for any copays and/or balance. I also authorize Family Health Care Center or insurance company to release any information required to process my claims.

Patient/Guardian Signature _____Relationship to Patient _____ Date _____

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TO BE FILLED OUT BY PARENT OR GUARDIAN

Child's Name:_____ Date of Birth:_____ Today's Date:_____

Mother's Name:_____ Age:_____ Occupation:_____

Father's Name:_____ Age:_____ Occupation:_____

Does the child attend Day Care or After School Care? (please circle) YES NO If Yes, Phone Number_____

PREGNANCY AND BIRTH

Mother's Age at birth _____

Did mother have any illness during pregnancy? NO YES

Did she take and medicines except vitamins/iron? NO YES

Was the baby on time? NO

What was the birth weight and length?_____lbs _____in

Did he/she have any trouble starting to breathe? NO YES

What type of delivery: C-Section Vaginal Forceps Vacuum

Any other problems in the hospital (jaundice, etc)? NO YES

If yes, what kind_____

PAST MEDICAL HISTORY

Where has you child gone for check-ups until now? _____

Date of last check-up? _____

Date of last dental check-up? _____

Any allergies to medicines, foods, insects? NO YES

If yes, Which ones?_____

Any hospitalizations? NO YES

Any Surgeries? NO YES

For what?_____

Any serious injuries (head, broken bones, wrecks?) NO YES

Any medications taken regularly? NO YES

Which ones?_____

Do you have record of immunizations? NO YES

FEEDING AND NUTRITION

Is his/her appetite usually good? NO YES

Was there severe colic or unusual feeding during the first 3 months? NO YES

Do any foods disagree with him/her? NO YES

Does he/she take vitamins? NO YES

Does he/she take fluoride? NO YES

For the first six months, was he/she breast/bottle fed? (Circle)

If still on formula, which one? _____

FAMILY HISTORY

Are the child's parents in good health? NO YES

Circle any diseases this child's family has had:

(include parents, brothers/sisters, grandparents, aunts/uncles, and cousins)

anemia, asthma, allergies, diabetes, TB, AIDS, high blood pressure, heart trouble, mental illness, drug or alcohol problems, inherited illness, cancer

List age, gender and general health of brothers and sisters:

_____

_____

Have any children died? NO YES

REVIEW OF SYSTEMS

1. Has your child had frequent ear infections? NO YES
2. Any Eye Problems? NO YES
3. Any problems with teeth? NO YES

YES 4. Does he/she have frequent colds? NO YES

5. Is there asthma, pneumonia, or recurrent cough? NO YES
6. Is there a heart murmur or heart problems? NO YES
7. Any problems with urination? NO YES
8. Ever had a UTI or Urinary Tract Infection? NO YES
9. Any constipation or diarrhea? NO YES

10. Any convulsions or nervous system problems? NO YES

11. Any eczema, hives, or other skin condition? NO YES

12. Any anemia? NO YES

13. Please list any other physical complaints _____

DEVELOPMENT AND BEHAVIOR

At what age did your child roll over? _____Months

At what age did your child sit alone? _____Months

Did he/she say any word by age one year? NO YES

Does the child seem advanced or behind others his/her age? NO YES

If yes, in what way?_____

Does he/she have trouble sleeping? NO YES

What grade is he/she in? _____

Any trouble in school (behavioral or academic)? NO YES

Circle if he/she has had any of the following:

nail biting, thumb sucking, bed wetting, problems with toileting, bad temper, hyperactivity, nightmares, speech problems, others

SAFETY ENVIRONMENT

Do you live in a house, apartment, mobile home, other (circle)

Any pets in the home? NO YES

Do you know the hottest temperature of the water heater? NO YES

Is there a working smoke alarm on each floor? NO YES

Does he/she always use a car seat/seat belt in the care? NO YES

Are there any smokers in the family? NO YES

Are there any problems in the condition of your home? NO YES

(peeling paint, insects, mice, no heat/air, etc) _____

Does he/she always wear a helmet when biking? NO YES

Do you have well water or city water? (circle)

Please explain any significant problems below:

_____

_____

_____

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Minor Patient Care Policy

Minor Patient Name: _____ Date of birth: _____

Thank you for choosing Family Health Care Center to provide healthcare to your minor. In order to remain compliant with HIPAA rules and regulations, Family Health Care Center has adopted the following policy regarding treatment of a minor:

All minor patients must be accompanied by a legal guardian/caretaker when coming to the office for treatment, unless the patient is coming in for reproductive health, or the office staff has received written authorization to treat the patient in the form of the Consent for Minor Patient to be Treated document.

Any lab results/procedures regarding reproductive health of a minor are protected by law and may not be disclosed without express consent of the minor patient. Therefore, lab results will not be disclosed over the phone to anyone but the patient, unless consent to release the results have been documented in the patient's chart by the treating provider.

If consent has not been given to release results over the phone, then an office visit with the minor patient and guardian must be scheduled to discuss results with the treating provider. For the health of the patient, treatment for any reproductive diseases/conditions that may have been uncovered during testing/procedures may begin prior to the office visit to discuss results with legal guardian/caretaker.

Family Health Care Center requires that a minor patient be seen and accompanied by a parent or legal adult guardian at the initial visit. If the parent or guardian would like the minor patient to be seen unaccompanied for any subsequent visits we must have signature authorization. Please fill out the form in its entirety and fax, mail, or deliver to the office.

Person giving consent for treatment:

Name: _____ Daytime Phone: _____

Relation (check one):

_____ Parent _____ Legal guardian _____ Caretaker

Authorization:

I give my consent to have _____ seen and treated by Family Health Care Center without my presence. I give Family Health Care Center the right to discuss and treat the above patient's disease, not limited to any prescriptions and procedures deemed necessary by providers at Family Health Care Center. I give consent for treatment to begin on the date listed below and understand that I may revoke this consent by giving Family Health Care Center written notice.

Parent/Guardian Signature _____ **Date**_____

**this form has no expiration date unless given written notice to discontinue.

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FHCC Insurance Disclaimer

Please be aware that you as the patient are responsible for any charges that are **not covered** by your insurance. **It is the patient's responsibility to make sure that our office is in network and is participating with your insurance plan.** It is also the patient's responsibility to know if the insurance requires you to have a designated Primary Care Provider (PCP).

If you are not sure if our office is participating with your plan **or** if your insurance requires you to have a dedicated PCP, please call the customer service number conveniently located on the back of the insurance card to verify participation make any necessary changes.

With insurance constantly changing and the implementation of the AFFORDABLE Care Act (Obamacare), Our office can NOT accommodate the phone calls required to make sure we are in network with every patient's insurance plan and/or call to verify if they will deny your medical claim due to missed premium payments.

We will file your insurance; this does not mean in any way that our office is a participating provider for your health plan, or that your insurance will pay for your visit. Therefore, you may receive an additional bill for any balances that were unpaid by your insurance. Please note that if your insurance premiums are not paid, any medical claims during that period will be denied or possibly pend.

For patients with PCPs different than the providers in our office- it is the patient's responsibility to change their PCP to the appropriate provider or to provide written documentation that a PCP is not required for the patient's specific plan. If you are currently in a grace period at the time of your visit, you will be treated as a SELF-PAY patient.

For patients that have managed health care plans- You MUST provide proof of FULL premium payment at the time of visit. If payments are not made by the end of your premium grace period, you will be held responsible for any and all charges for treatment from your visit. Therefore, any patient that is currently in a grace period will be treated as a SELF PAY patient.

Patient Name _____ Date _____

Patient/Legal Guardian Signature _____

***This form does not have an expiration date

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PLEASE REMEMBER:

Photo ID Insurance Card Copays All Medications Currently Prescribed

Patient Insurances Preferred Services

Many insurance companies are now specifying which commercial laboratories, hospitals, radiology services and other services you may use for studies. It is YOUR responsibility as the patient to be aware of this information. For instance, if your lab work is sent to a non-preferred lab you will be responsible for payment.

Our in-office lab can perform only limited testing and when appropriate, we will perform what we can in-house. All other specimens must be sent to a reference lab such as labcorp.

Please indicate your insurance carrier's preferred lab and/or radiology services. Inaccurate or erroneous information will results in you being held responsible for all lab charges. If you are unsure, please contact your insurance carrier by calling the customer service number listed on the back of your insurance card.

Laboratory:

Lab Corp_____

Quest Diagnostics_____

Other_____

Radiology Services:

East Georgia Regional Medical Center_____

Other_____

By signing this document, I hereby acknowledge that I understand and agree to its content.

Patient/Guardian

Signature_____**Date**_____

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Patient Acknowledgement

Review or Receipt of Notice

I understand FHCC has a legal responsibility to protect patient privacy. To do this, the practice strives to keep patient information confidential and to safeguard the privacy of all patient information.

I understand the FHCC has the authority to use and disclose my private health information to carry out treatment, payment, and healthcare operations, and that my private health information will not be released to other activities unless I sign a release authorizing this disclosure.

By signing this form, I acknowledge that I have been provided with FHCC's Notice of Privacy Practices to review, and have been informed that I may obtain a copy upon request.

I understand that Family Health Care Center has the right to change its Notice of Privacy Practices. If so, FHCC will issue a revised Acknowledgement of Review/Receipt of Privacy Practices.

Patient Printed Name_____

Patient/Guardian Signature _____**Date**_____

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HIPAA FORM

PATIENT NAME_____DATE OF BIRTH_____

1. Please list any family member or other persons / physicians to whom Family Health Care Center may release information concerning your medical records:

   NAME_____PH#_____Relationship_____

   NAME_____PH#_____Relationship_____

   NAME_____PH#_____Relationship_____

   Please Note: Our automated computer system will automatically call all patients with appointments 2 days prior to the scheduled appointment date. Please confirm YES with the system by pressing #1 or cancel the appointment by pressing #2.

   Please list the best number for all **appointment reminder calls**

   _____

2. May Family Health Care Center leave messages on your home answering machine or voicemail? Please Circle : YES or NO
3. Please indicate if you would like to create a patient portal account. With this account, you will be able to review your lab results, ask non-urgent medical questions, request medication, and schedule appointments.
   Would you like to enroll? Please Circle: YES NO

Patient/Guardian

Signature_____**Date**_____

Parent/Guardian of minors under age 18 has access to medical records, with the exception of any State Law protecting the privacy of information of minors.

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This will remain in effect until I give written notification to discontinue.

Administrative Policy

1. Family Health Care Center (FHCC) is striving to do everything possible to hold down the cost of medical care to all by ensuring proper payment to our office. You, the patient, can help us by adhering to the following administrative policy. By signing at the bottom of the Administrative Policy, you are indicating that you understand our policies and agree to adhere to them. If you have questions prior to signing, please ask at the front desk.

    a. Appointments:

        i. It is a patient's responsibility to provide FHCC with complete and correct information. You must bring your current insurance cards to each visit. If you fail to do so and your new insurance requires a preauthorization or we find that our services will not be reimbursed, or we are unable to properly bill your insurance, any balances will become the patient's responsibility.

        ii. It is the new patient's responsibility to complete all patient and medical history forms at the time of their visit.

        iii. All appointments must be cancelled at least 24 hours in advance. If you fail to cancel the appointment and do not show up, a $25 No Show fee will be assessed to your account. If you continue to neglect to show up for appointments, we may have no other option except to dismiss you from our practice. Please understand that this patient practice is costly to our office.

        iv. All patients are required to provide their Social Security Number upon their initial visit. Under no circumstances will a patient be allowed to be seen without providing it. FHCC respects your privacy and will not share your personal information with anyone other than your insurance carrier, Collection Agency, or whomever you have agreed in writing to allow access to your account or health information.

    b. Insurance:

        i. FHCC will bill all participating insurance carriers as a courtesy to our patients. **If your insurance fails to pay your claim within 60 days from the date it is billed, the balance will become the patient's responsibility**.

        ii. Assignment of Benefits: By signing this policy the patient or guarantor authorizes payment of medical benefits to FHCC for all in-network insurance carriers.

        iii. Appeals: By signing this policy, the patient or guarantor agrees to allow FHCC to submit and follow up on medical appeals on behalf of the patient.

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iv. Cooperation: The patient or guarantor agrees to cooperate with the insurance company and with FHCC to provide any information necessary to properly process the medical claim.

c. Payments:

i. All copays, co-insurances, and deductibles are due at the time of service. All payments may be made via cash, check, or credit card (Visa, MasterCard, Discover, American Express, Debit Card). Any payment made by check will be processed electronically and will be automatically debited from your account within 24 hours.

ii. Credit Card Payments: Your signature at the bottom of this policy will stand as a signature on file for any payment you authorize by credit card via the telephone, fax or Internet.

iii. Returned checks: All accounts will be assessed a $40 processing fee for returned checks. If you fail to reimburse FHCC within 10 days of notification from your bank, you will not be allowed to use a check for any future payments.

iv. Out of Network Patients: If FHCC is not a participant in your insurance network, you will be required to pay the portion of your balance not paid by your insurance company.

v. Uninsured Patients: You will be considered a Self Pay Patient (see paragraph vi below).

vi. Self Pay Patients: You must bring a minimum of $150 to each visit. This does not mean your visit will be less than $150. It will depend on the type of visit and/or any tests or procedures that may be provided. If you pay your balance at the time of service we will provide a 30% discount at Check Out. If you have insurance of which we do not participate with, our staff will provide you with an encounter receipt which will include all information necessary for you to be reimbursed by your insurance carrier. All balances to FHCC will be due at the time of service.

d. Collections:

i. Patient Balances: Balances including copays, co-insurances, and deductibles that are not paid in full at the time of service creates costs to FHCC. Balances are due at your office visit.

ii. If you have a balance after your insurance has paid, you will receive a statement to be paid within 2 weeks of receipt. If after 2 statements have been sent and FHCC has not received your payment due at 60 days, we may attempt a courtesy phone call requesting that you return our call. If no payment is received, at 90 days

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your balance will be turned over to a collection agency. FHCC will add a 30% collection fee to your total balance to cover collection costs incurred by FHCC.

e. Hospital Admissions:

i. Dr. Riley believes that you are entitled to make informed decisions regarding your medical care. To assist you in making an informed decision, Dr. Riley hereby notifies you that he has an ownership interest in East Georgia Regional Medical Center, which is a physician-owned hospital, pursuant to 42 C.F.R § 4.89.3.

2. Please address any questions to the front office staff or to our billing/insurance staff at (912) 489-4090, ext 127, 128 or 129.
3. Anyone who fails to comply with any part of our policy may be asked to reschedule so you will have time to comply with the policy. Those who repeatedly miss appointments, are noncompliant with a plan of care, or are abusive to our staff may be rescheduled or dismissed from our practice.
4. If you have any additional questions or concerns you may contact the Practice Administrator at (912) 489-4090, ext 123.
5. This policy remains in effect until superseded. You will be provided a copy of this policy upon request.

Patient Printed Name _____

Guarantor Printed Name _____

Patient/Guardian Signature _____**Date** _____

Account # _____

Employee Initials: _____

07/11/2009

FHCC Administrative Policy

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Dear Patient,

Thank you for choosing us to provide healthcare for you and your family. We at Family Health Care Center constantly strive to provide you with the ultimate patient experience and customer service. We are excited to offer an online patient portal for our patients so that you can have faster, reliable communication that is accessible to you at all times.

Our internet-based patient portal, Next MD, simplifies communication with your physician or provider and eliminated time-consuming phone calls to the practice. Whether you want to **schedule an appointment or review your test results**, the patient portal delivers the information you need through a convenient, easy-to-use patient portal.

NextMD is a secure, confidential, and easy-to-use website that gives patients 24-hour access to their medical information. It uses the latest encryption technology to deliver secure communication between patient and our office. By signing up and enrolling in NextMD, you will be able to:

- Correspond online with Family Health Care Center, that is channeled to proper personnel for quicker response times
- Request appointments and receive appointment reminders
- Access important health information from your medical record including: medications, immunizations, and test results
- View medication lists and request prescription refills directly through your provider/provider nurse
- Obtain educational information
- Maintain account information including username, password, access privileges, and email address

How do you sign up?? Patients and their legal guardians can sign up for NextMD. All you have to do is provide your name and email address to us below. We will then provide you with and instruction sheet with a temporary password or enrollment token. The enrollment token will allow you to log in to the system and create your own private username and password. After you sign up and begin using the patient portal, Next MD will generate a notice that will be emailed to your personal email account to notify you that you have important information waiting in you NextMD account.

We look forward to providing this service to you and hope that you will take advantage of its many benefits.

_____Yes, **I have an email** and would like to sign up for NextMD, your online patient portal.

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Email Address: _____ DOB: _____

_____No, I do not have an email at this time in order to sign up for NextMD services.

_____No, I am just not interested in signing up for NextMD at this time.

Thad H. Riley M.D. • Angela Davis M.D. • Susan B. Riley, CDE, FNP, DNP • Alexandra Wilson FNP-C • Kelly Tillman, FNP-BC

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

(THIS FORM MUST BE COMPLETED IN FULL TO RECEIVE RECORDS.)

Name of Patient _____ Date of Birth_____

Street Address_____ City, State, Zip Code_____

I authorize the use and/or release of my protected health information as described below. I understand that the information used or released as a result of this Authorization may no longer be protected by federal privacy laws and may be further used or released by persons or organizations receiving it without obtaining my authorization. I may refuse to sign this Authorization, which will not affect my ability to obtain treatment or payment of claims. I have the right to revoke this authorization by providing written notice to Family Health Care Center. Revocation of this Authorization will not affect any action taken before receipt of the written revocation.

I AUTHORIZE:	TO RELEASE PROTECTED HEALTH INFORMATION TO:
_____	_____
Name of Physician / Health Care Facility / Other	Name of Physician / Health Care Facility / Other
_____	_____
Street Address	Street Address
_____	_____
City, State, Zip Code	City, State, Zip Code

HEALTH INFORMATION TO BE RELEASED:

O All Medical Records O Immunization Records O Lab Reports O X-ray Reports O Billing Records

O Other (describe) _____

OR THE FOLLOWING DATE(S) OR TIME FRAME (MM/DD/YYYY): From:_____/_____/_____ To: _____/_____/_____

Federal and state laws require special permission to release certain information. Please check if these records SHOULD BE released:

O Mental Health O Alcohol and/or drug abuse O HIV/AIDS test results O Developmental disabilities

PURPOSE OR NEED FOR DISCLOSURE: (Check Applicable Categories)

O Further Medical Care O Patient's Request O Insurance/Eligibility Benefits O Disability Determination O Legal Investigation

O Other (please describe)_____

EXPIRATION: This authorization will expire on ____/____/_____. If I do not indicate a date, this will expire one (1) year from the date on my signature below.

A photocopy of this authorization is a s valid as the original.

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SIGNATURE: I understand that this authorization is voluntary. I am confirming my authorization that the health care provider may use and/or disclose to persons and/or organizations named in this form the protected health information described in this form.

Signature_____Date:_____

If this authorization is signed by a representative on behalf of the patient, complete the following:

Representative's Name:_____Relationship to patient:_____