23702 U.S. Highway 80 East
Statesboro, Georgia 30461
(912) 489-4090
Fax (912) 764-5028
www.familyhealthcarecenter.com

# Family Health Care Center

Thad H. Riley, M.D. | Angela Davis, M.D. | Zach McGalliard, M.D. | Alex Weathersby, FNP-BC | Kelly Tillman, FNP-BC | Kellie Whitener, FNP-BC

## NEW PATIENT REGISTRATION

Please complete & sign this form in its entirety before the end of your first appointment. It is important that all information completed be accurate and up to date. Please use your legal first and last name.
Return to the front desk when complete.

**PATIENT INFORMATION:** Mr.___Mrs. ___Miss ___Ms. ___

Patient Name: ______________________________________________
*Last* *First* *MI*

Please Circle: Single / Married / Divorced / Widowed Race: ______________________ Sex: M ____ F ____

Hispanic, Latino, Spanish: Y / N Date of Birth: ____/____/_______ SSN: _______-________-____________

Physical Address: ______________________________City: ______________________ St:____ Zip:_________

Primary Phone: (______) _______-_________ Cell / Home Secondary Phone: (______) _______-_________

Email Address: ______________________________________________

Occupation: ______________________________ Employer: ______________________________

Employer Phone: (______) _______-_________ Is this visit/injury work related? Yes_______ No_______

Preferred Pharmacy____________________________________________ Location: ______________________________

Referred By: Dr.____ Family____ Friend_____ Other_____

In Case of EMERGENCY:

Please list the name of local friend or relative (not living at same address):

Name: ________________________________________________

Relationship: ______________________________ Contact Phone: (_____) ______-_________

**IF PATIENT IS NOT HIS/HER OWN GUARANTOR:**

Parent/Guardian Name: ______________________________________________

Parent/Guardian DOB: ____/____/_______ Contact Phone: (______) _______-__________

Mailing Address: ___________________________________________ City_________________ St ____ Zip __________

# Medical History

| CONDITION | YOU (Yes or No) | RELATIVE (Yes or No) | CONDITION | YOU (Yes or No) | RELATIVE (Yes or no) |
|---|---|---|---|---|---|
| High Blood Pressure | | | Migraine Headaches | | |
| Heart Attack | | | Seizures | | |
| Congestive Heart Failure | | | Kidney Problems | | |
| Asthma | | | Stomach Ulcer | | |
| Emphysema/COPD | | | Gallstones | | |
| Tuberculosis | | | GERD/Reflux | | |
| Diabetes | | | Constipation | | |
| Thyroid Disease | | | Depression | | |
| Anemia | | | Mental Illness (Please List) | | |
| Leukemia | | | Arthritis | | |
| Sickle Cell | | | Glaucoma/Eye Problem | | |
| Bleeding Problems | | | Cancer | | |

## Other Current or Past Medical Conditions Not Listed Above

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

## Current Medications

**Preferred Pharmacy & Location:**

| MEDICATION NAME | STRENGTH | DIRECTIONS | MEDICATION NAME | STRENGTH | DIRECTIONS |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## Known Medication Allergies

| MEDICATION | REACTION |
|---|---|
| | |
| | |
| | |
| | |
| | |

## Surgical History

| Type/Location | Doctor | Date |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## Hospitalizations

| Hospital/Date | Reason |
|---|---|
| | |
| | |
| | |
| | |

## Social History (Please Check)

| | | |
|---|---|---|
| Do you use tobacco products? ☐ Yes ☐ No | What kind? ☐ Cigarettes ☐Chewing tobacco ☐Vaping ☐ Snuff | |
| How much do you use daily? | How long? (Years/Months) | Interested in quitting? ☐Yes ☐No |
| Do you consume alcohol? ☐ Yes ☐No | How often? ☐ Seldom ☐ Socially ☐ Daily | What kind? |
| Mother: ☐Alive ☐ Deceased | Cause of Death: | |
| Father: ☐Alive ☐ Deceased | Cause of Death: | |
| Siblings: ☐ Yes ☐ No | Number of Brothers: | Number of Sisters: |
| Children: ☐ Yes ☐ No | How many? | |
| Do you see a Specialist? Yes No | Providers Name and Specialty: | |

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## OBGYN History

Please print your current OBGYN: ________________________________ Phone: ______________________

MENSTRUAL HISTORY (complete even if post-menopausal or no longer having periods)

1. Age at first period: _______ years.
2. Are your periods regular or irregular? _______________
3. If your menstrual periods are regular; periods start every: ___________ days
4. Average duration of bleeding: _____ days
5. Does bleeding or spotting occur between periods? ☐ Yes ☐ No
6. Does bleeding or spotting occur after intercourse? ☐ Yes ☐ No
7. First day of last menstrual period ____________________
8. Is pain associated with periods? ☐ Yes ☐ No ☐ Occasionally
9. If yes to previous question, is it: before menses? ________ during menses? ________ both? __________
10. Do you use birth control? ☐ Yes ☐ No If yes, what form (pill, implant, IUD)? __________________

Number of Pregnancies: _____________

Number of Live Births: _____________

Have you ever had a miscarriage, abortion, or still birth? If yes, please list with year: ____________________________

______________________________________________________________________________

______________________________________________________________________________

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## Minor Patient Care Policy

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.

**Consent for Minor Patient to be Treated**
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.

Minor Patient Name: ____________________________________ DOB: ____________________

**Person giving consent for treatment:**

Name: ____________________________________________________________________________
Contact Number: __________________________________

Relationship to minor (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.

___________________________ ______________
Guardian Signature Date

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

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## INSURANCE INFORMATION

Primary Insurance:

Insurance Company: ______________________________________________ Policy #__________________________

Subscriber Name: ______________________________________________ Subscriber DOB: ______/______/_________

Relationship to Subscriber: ______________________________________ Subscriber SSN: ______-_______-_________

Secondary Insurance (if applicable):

Insurance Company: ______________________________________________ Policy #__________________________

Subscriber Name: ______________________________________________ Subscriber DOB: ______/______/_________

Relationship to Subscriber: ______________________________________ Subscriber SSN: ______-_______-_________

______ Please Initial if you are opting to be a self-pay patient, meaning you will be responsible for any and all charges accrued at the time of service. Payment for self-pay patients is due at the beginning of every visit, any additional charges will be collected at check-out.

By signing I agree that 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, as the patient, am responsible for **any copays and/or balances** not covered or left by insurance. I also authorize Family Health Care Center or insurance company to release any information required to process my claims.

**Patient Signature ________________________________________________ Date: _____________________**

**Guardian (if patient is a minor) Signature ______________________________________________________**

**Relationship (if not patient): ____________________________________**

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## Patient Insurances Preferred Services

Many insurance companies are now specifying which commercial laboratories, hospitals, radiology services and other services you may use for tests & 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 ordered by our providers and when appropriate, we will perform what we can in-house. All other specimens must be sent to a reference lab such as LabCorp. This means any outside lab orders preformed at this facility will be billed through LabCorp NOT Family Health Care Center.

Please indicate your insurance carrier's preferred lab and/or radiology services. Inaccurate or erroneous information will result 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.

Please check your insurances preferred service:

**Laboratory**:
____LabCorp
____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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## FHCC Insurance Disclaimer

Please be aware that you 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 our office is participating with your plan, or if your insurance requires you to have a dedicated PCP, please call the customer service number located on the back of the insurance card to verify participation and to make necessary changes.

With insurance constantly changing and the implementation of the AFFORDABLE Care Act (Obamacare), there is no way our office can 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 if your PCP listed is not one of our providers. 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 pending**.

**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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# HIPAA ACKNOWLEDGEMENT & PATIENT CONSENT

I. CONSENT FOR TREATMENT: I hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my physician(s). I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician(s). I understand that my medical care may require the collection of samples, including fluids or tissues, from my body. This may include having blood drawn or tissues removed during tests, treatment, or surgery. Further, I understand that should any medical personnel or other person(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including Hepatitis Band C as well as HIV/AIDS. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examination. I have the right to refuse tests or treatment (as far as the law allows) and to be told what might happen if I do. I have the right not to have any photos or videos taken of me unless I agree to this, except as needed to treat me. I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

II. NOTICE OF PRIVACY PRACTICES: Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Acknowledgement. The terms of our Notice may change; if we change our notice, you may request a revised copy by contacting our office or you will receive a new notice the next time you are treated at our office. The Clinic provides this form to comply with the Health Information Portability and Accountability Act of 1996 (HIPAA).

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 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.
- 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.

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings, and care decisions to the individuals listed below. Please note that this does not allow these individuals to obtain copies of my medical records without a complete and valid authorization from me.

Patient Printed Name: ______________________________________________________________

**Patient/Guardian Signature ____________________________________________________**

**Date______________________**

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## Appointment Cancellation & No-Show Policy Acknowledgement

1. Missed Appointments: we understand that there are times when you must miss your appointment due to unforeseen circumstances. However, when you do not call to cancel an appointment, you may be preventing another patient from receiving much needed treatment. This practice requires 24-hours advanced notice if you are unable to keep your scheduled appointment. If your appointment is not canceled at least 24 hours in advance, you will be charged a $50 no-show fee.
2. Scheduled appointments: we understand that delays may happen on the day of your scheduled appointment. Because we make every effort to keep patients and providers on schedule, it is imperative that you arrive on time for your scheduled appointment (or 15-mins early to complete any paperwork). Arriving late to your scheduled appointment causes the providers and timely patients to be pushed behind. If you arrive 15 minutes or later than your scheduled appointment time, we reserve the right to reschedule your appointment.
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. Family Health Care Center reserves the right to discharge a patient (at the providers discretion) once the patient has accumulated four or more no shows within an 18-month time period.
5. This policy remains in effect until superseded. You will be provided a copy of this policy upon request.

**If you fail to cancel or reschedule within 24 hours of your scheduled appointment, fail to show up for the appointment, or show up more than 15 minutes late for the appointment; you may be charged a $50 no-show fee (this fee does not apply to Medicare or Medicaid patients). This fee is not covered by insurance, and you will be responsible for paying the fee prior to your next visit.**

Due to insurance contacts **ALL COPAYMENTS** are due at the time of your appointment. Copayments will be collected PRIOR to services being rendered. If you do not have your copay upon check-in, your appointment will be rescheduled. Family Health Care Center requires that any uninsured/self-pay patient bring a minimum of $150 to their scheduled appointment.

**Account Balances:** **ACCOUNTS WITH BALANCES MUST MAKE A PAYMENT AT EACH APPOINTMENT**. Accounts with no payments within 90 days will be turned over to collections. **If your balance is greater than $300, you must make payment arrangements with the office Accounts Specialist prior to your appointment being scheduled.**

______________________________ ________________
Print Name Date

______________________________
Signature

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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 list the best number for all appointment reminder calls: (______) ______-__________

**Please Note: Our automated text reminder will automatically text all enrolled patients with appointments prior to the scheduled appointment date. Please reply YES to confirm.**

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 Already Enrolled

4. If permissible, please provide an email address to create a patient portal account.
   EMAIL: _____________________________________________________________

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

Patient or Guardian Signature: _____________________________________DATE: __________________

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

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## AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

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:** |
|---|---|
| ______________________________<br>Name of Physician / Health Care Facility / Other<br>______________________________<br>Street Address<br>______________________________<br>City, State, Zip Code | **Family Health Care Center**<br>**23702 US Hwy 80 E**<br>**Statesboro, Ga 30461**<br>P: 912-489-4090 F: 912-764-5028 |

**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.
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: ________________