

IN CASE OF EMERGENCY (NOT LIVING WITH): _____ PHONE _____

REFERRED BY _____

COPIES OF INSURANCE CARD AND DRIVERS LICENSE WILL BE MADE UPON EACH VISIT FOR YOUR FILE.

WE ARE LEGALLY BOUND TO COLLECT YOUR COPAY AT TIME OF EACH VISIT. IF YOU ARE UNABLE TO PAY YOUR COPAY, WE WILL NEED TO RESCHEDULE YOUR VISIT FOR ANOTHER DATE.

_____ (OPTIONAL) MAY BE CONTACTED BY PHONE, EMAIL, TEXT, OR MAIL REGARDING MY TREATMENT WITH FAMILY MEDICINE ASSOCIATES OF AUGUSTA. THIS INCLUDES BUT NOT LIMITED TO APPOINTMENT REMINDERS, LAB RESULTS, XRAY RESULTS, REFERRALS ETC...

THIS AUTHORIZATION IS IN EFFECT AS OF:

DATE _____ SIGNATURE _____

PLEASE SIGN BELOW IF YOU WISH **NOT** TO BE CONTACTED BY PHONE, EMAIL, TEXT, OR MAIL REGARDING YOUR TREATMENT WITH FAMILY MEDICINE ASSOCIATES OF AUGUSTA.

THIS AUTHORIZATION IS IN EFFECT AS OF:

DATE _____ SIGNATURE _____

MEDICARE LIFETIME ASSIGNMENT

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE TO FAMILY MEDICINE ASSOCIATES OF AUGUSTA FOR ANY SERVICES FURNISHED TO ME BY THIS PROVIDER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTHCARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE BENEFITS PAYABLE FOR RELATED SERVICES.

THIS AUTHORIZATION IS IN EFFECT AS OF:

DATE _____ SIGNATURE _____

CONSENT FOR EXAMINATION, DIAGNOSIS,
TREATMENT AND MEDICAL CARE

I am presenting myself or _____
(Name of Patient)

My _____
(Relationship to Patient)

For examination, diagnosis, and treatment by the Physicians of Family Medicine Associates of Augusta, and other Physicians in practice with them or with whom they may consult and voluntarily consent to such examinations, diagnostic tests and procedures, and such other medical treatments, procedures and care as said physicians may deem necessary or appropriate in their professional judgment. Said tests, treatments, and procedures may be performed by the employees and agents of said physician(s).

Date _____

Patient's Signature _____

Signature
Parent/Guardian _____

Witness _____

EFFEC. APRIL 14, 2003

Family Medicine Associates of Augusta
Notice of Privacy Practices

This notice describes how medical information about you may be used
And Disclosed and how you can get access to this information.

Please review carefully

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use of 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 categories.

FOR PAYMENT. We may use and disclose medical information about you so that the treatment and services you receive at the Practice may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may disclose your record to an insurance company so that we can get paid for treating you.

FOR TREATMENT. We may use medical information about you to provide you with medical treatment or services. We may disclose medication about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the Practice or the hospital. For example, we may disclose medical information about you to people outside the Practice who may be involved in your medical care, such as family members, clergy, or other persons that are part of your care.

FAMILY MEDICINE ASSOCIATES OF AUGUSTA HAS THE RIGHT TO REVIEW AND OBTAIN MY PAST
MEDICATION HISTORY.

FOR HEALTH CARE OPERATIONS. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the Practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other Practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

WHO WILL FOLLOW THIS NOTICE. This notice describes our Practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff, and other Practice personnel.

Policy regarding the protection of personal information. We create a record of the care and services you receive at the Practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the Practice, whether made by Practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private, give you this notice of our legal duties and privacy Practices with respect to medical information about you, and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information includes: appointment reminders, as required by law, for health related benefits and services, to individuals involved in your care or payment for your care, research, to avert a serious threat to health or safety, and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners

and funeral directors, health oversight activities, inmates, law enforcement, lawsuits and disputes, military and veterans, national security and intelligence activities, organ and tissue donation, protective services for the president and others, public health risks, and workers compensation.

Notice of individual rights

You have the following rights regarding medical information we maintain about you:

RIGHT TO AN ACCOUNTING OF DISCLOSURES. You have the right to request an “Accounting of Disclosures”. This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the privacy officer.

RIGHT TO AMEND. If you feel that medical information we have about you is incorrect or incomplete, you may 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, the Practice. To request an amendment, your request must be made in writing and submitted to the privacy officer and you must provide a reason that supports your request. We may deny your request for an amendment.

RIGHT TO INSPECT AND COPY. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

RIGHT TO PAPER COPY OF THIS NOTICE. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing, and you must specify how or where you wish to be contacted.

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 healthcare operations. You also have 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 for your care, like a family member or a 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 restrictions, you must make your request in writing to the privacy officer.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the Practice’s waiting room.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the secretary of the Department of Health and Human Services, Office of Civil Rights, Hubert H. Humphrey Building, 200 Independence Ave., Washington, DC 20201. To file a complaint with the Practice, address to Privacy Officer, Family Medicine Associates of Augusta, 1417 Pendleton Road, Augusta, GA 30904. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

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. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer at (706) 738-9824.

MEDICAL HISTORY FORM

Date: / /

This information is for use by your physician as part of your confidential medical record

Name _____ Age _____ Birth date _____

Address: _____ Sex M F

Home Phone _____

Work Phone _____

Occupation _____ Emergency contact _____

Phone _____

Single Married Divorced Widowed Separated

If married, spouse's name _____

Children's names and ages _____

Allergies to Medications, X-ray dyes, or other substances No Yes

(if yes, please list names of medicine and types of reaction)

Past Medical History

Please circle if you have had problems with the following:

- | | | |
|------------------------|---------------------------|-----------------------|
| 1. High blood pressure | 10. Ulcers | 19. Low back problems |
| 2. Diabetes | 11. Hemorrhoids | 20. Skin diseases |
| 3. Cancer | 12. Gall bladder disease | 21. Blood disorders |
| 4. Heart disease | 13. Colitis | 22. Venereal diseases |
| 5. Rheumatic fever | 14. Hepatitis or jaundice | 23. Anemia |
| 6. Asthma | 15. Thyroid disease | 24. Alcohol abuse |
| 7. Persistent cough | 16. Kidney diseases | 25. Drug abuse |
| 8. T.B. | 17. Kidney stones | 26. Gout |
| 9. Hay fever | 18. Arthritis | |

Gynecologic and Obstetric History (Female Patients Only)

Age at onset of periods: _____ Frequency: _____ Length of period: _____

Pregnancies: _____ Births: _____ Miscarriages: _____

Prolonged or abnormal bleeding: No Yes (please describe) _____

Leakage of urine: No Yes (please describe) _____

Pelvic pain: No Yes (please describe) _____

Abnormal discharge: No Yes (please describe) _____

Abnormal pap smear: No Yes (type of treatment) _____

-OVER-

RECORDS RELEASE TO FMA

TO: _____
Doctor/Hospital

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

I hereby authorize a copy of my medical records to be sent to:

**FAMILY MEDICINE ASSOCIATES OF AUGUSTA
1417 PENDLETON ROAD
AUGUSTA GA 30904
(706) 738-9824**

PRINT NAME OF PATIENT

DATE

DATE OF BIRTH

SS # OF PATIENT

SIGNATURE OF PATIENT

FAMILY MEDICINE ASSOCIATES OF AUGUSTA
1417 PENDLETON ROAD
AUGUSTA, GA 30904
(706) 738-9824

WAIVER OF LIABILITY FOR POSSIBLE DENIAL OF
TEST/PROCEDURES PERFORMED BY OUR
PHYSICIANS FOR INSURANCE PAYORS
MEDICARE AND HMO/PPO CARRIERS

PATIENT NAME _____

WE BELIEVE THAT IN YOUR CASE, YOUR INSURANCE COMPANY IS LIKELY TO DENY PAYMENT FOR TESTS AND/OR PROCEDURES PERFORMED TODAY. THESE TESTS AND/OR PROCEDURES ARE, BUT NOT LIMITED TO:

- | | |
|-----------------------|--------------------|
| CHEMISTRY PANELS | X-RAYS |
| STREP TEST | CBC |
| PREGNANCY TEST | HEMOCCULT |
| STEROID INJECTIONS | HORMONE INJECTIONS |
| B 12 INJECTIONS | GTT |
| EKG | PHYSICALS |
| LASER SURGERY | NAIL REMOVAL |
| SKIN TAG/MOLE REMOVAL | OTHER _____ |

PLEASE READ AND SIGN THE FOLLOWING STATEMENT:

MY PHYSICIAN, OR HIS/HER REPRESENTATIVE, HAS INFORMED ME THAT MY INSURANCE COMPANY IS LIKELY TO DENY OR DECREASE PAYMENT FOR THE SERVICES INDICATED ABOVE. SHOULD THIS OCCUR, I AGREE TO BE RESPONSIBLE FOR PAYMENT OF THESE SERVICES TO MY PHYSICIAN.

SIGNATURE OF PATIENT _____

DATE OF SERVICE _____

Please list and supply the dates of:
Operations:

Hospitalizations other than for surgery:

Immunization History – have you had:

Pneumovax Immunization [] No [] Yes When? _____ Hepatitis B? [] No [] Yes When? _____
Flu immunization [] No [] Yes When? _____ Other [] No [] Yes When? _____
Tetanus immunization [] No [] Yes When? _____

When was your last:

Pap smear? _____ Breast exam? _____ Stool check for blood? _____
Mammogram? _____ Cholesterol check? _____ Prostate exam? _____

Family History

Has any member of your family (including parents, grandparents, and siblings) ever had the following?

Illness	Which family member?	Approximate age when diagnosed
Cancer (describe type)	_____	_____
Hypertension (high blood pressure)	_____	_____
Heart disease	_____	_____
Diabetes	_____	_____
Strokes	_____	_____
Mental disease (anxiety, depression, etc)	_____	_____
Drug or alcohol addiction	_____	_____
Glaucoma	_____	_____
Bleeding disease	_____	_____
Other:	_____	_____

Prevention

Do you wear seat belts? [] Yes [] No If not, why not? _____
Do you wear a bike helmet? [] Yes [] No [] N/A
Do you exercise regularly? [] Yes [] No If yes, type, duration, and number of times per week _____
Do you smoke? [] No [] Yes If yes, how many packs per day? _____
Do you drink alcoholic beverages? [] No [] Yes If yes, how much per week? _____
Do you drink coffee? [] No [] Yes If yes, how many cups per day? _____
Do you drink tea? [] No [] Yes If yes, how many cups per day? _____
If there is a gun in your home, do you keep it unloaded and out of children's reach? [] Yes [] No [] N/A
Do you use drugs? (marijuana, cocaine, crack, etc) [] No [] Yes If yes, explain: _____
Have you ever engaged in any activity which has put you at risk of getting AIDS? [] No [] Yes If yes, explain: _____
Do you wish to be tested for AIDS? [] No [] Yes
Have you ever worked with chemicals, paints, asbestos, or other hazardous material? [] No [] Yes If yes, explain: _____
Are you in a relationship in which you have been physically hurt (slapped, kicked, punched, bruised) by your partner? [] No [] Yes
Do you ever feel afraid of your partner? [] No [] Yes [] N/A
Do you have a "living will"? [] No [] Yes
Do you have a donor card? [] Yes [] No
Method of birth control? _____

SYMPTOM SURVEY

Patient Name: _____ Date: _____

Instructions: Start with the first symptom and ask yourself, “over the last week, have I experienced this symptom?” If yes, mark an x beside the symptom.

1. GENERAL

- Fatigue (sluggish/tired)
- Hyperactive (nervous energy)
- Restless (can't relax/sit still)
- Sleepiness during the day
- Insomnia at night
- Dizziness

2. ENT

- Headache (any kind)
- Earache
- Ear infection
- Discharge from ears
- Itchy ears
- Ringing in the ear(s)
- Post nasal drip
- Sinus pain
- Runny nose
- Stuffy nose
- Sneezing

3. CARDIOVASCULAR

- Irregular heart beat
- High BP
- Dizziness/lightheadedness
- Weak spells/fainting
- “Pounding in the chest”
- Palpitations/fluttering or flip-flop
- Chest pain
- Tightness/heaviness in the chest
- Indigestion-like pain
- Shortness of breath
- Sensation of choking
- Intermittent jaw pain
- Tingling arm
- Back pain between shoulder blades
- Wheezing

4. GI

- Heartburn/Esoph Reflux
- Stomach pains/cramps
- Intestinal pains/cramps
- Constipation
- Diarrhea
- Bloating sensation
- Gas (of any kind)
- Nausea, vomiting
- Painful elimination

5. MS

- Joints pains/aching
- Stiff joints
- Muscle aches
- Stiff muscles
- Arthritis (diagnosed)

6. DERM

- Blemishes. acne
- Rashes, hives
- Eczema
- “Rosey” cheeks

7. NEURO

- Leg cramp when sitting
- Feet get cold or numb
- Legs hurt walking a lot
- Sores – legs not healing
- Tingling in the legs
- Sleeping difficulties

8. PSYCH

- Depression
- Anxiety (vague fears/uneasiness)
- Mood swings (rapid distinct changes)
- Irritability
- Forgetfulness

9. HEME

- Enlarged lymph nodes
- Bleeding
- Skin discoloration
- Abnormal bruising
- Fevers

Patient Name: _____ Date: _____

PREVENTATIVE CARE:

When was your last: Hemocult? Date: _____

Colonoscopy? Date: _____

Mammogram? Date: _____

Pap Smear? Date: _____

PSA? Date: _____

If Diabetic, when was your last: Eye Exam? Date: _____

Foot Exam? Date: _____

IMMUNIZATIONS:

When was your last: Flu Vaccine? Date: _____

Pneumovax? Date: _____

Tetnus? Date: _____

HISTORY:

- 1. Have you or any of your immediate family members had heart disease? [] YES [] NO
- 2. Have you or any of your immediate family members had diabetes? [] YES [] NO
- 3. Have you recently started or stopped smoking? [] YES [] NO
- 4. Have you recently started an exercise program? [] YES [] NO
- 5. Have you fallen in the last year due to dizziness or vertigo? [] YES [] NO
- 6. Have you gotten dizzy after standing up quickly on multiple occasions? [] YES [] NO

Patient Sign: _____ Date: _____