Ocmulgee Physicians, LLC

446 Poplar Street Suite B
Macon, Ga. 31201

Patient Information

Last Name_______________________________First Name________________________M.I.________

Address____APT#________City_______________

State________Zip__________Home Phone(_____)______-_______ Cell Phone(_____)_______-_______

SSN_______-______-_______DOB_____/_____/______Sex(M)_____(F)______Race_________________

Email____ Marital Status (Circle) S M W D

Employer____________________________________Occupation_______________________________

Preferred Language__________________________ Ethnicity (Circle) Hispanic Non-Hispanic

Emergency Contact____

Relationship_____________________________________Phone Number_(_____)________-__________

Primary Insurance Company_________________________________I.D.#_______________________

Subscriber's Name______________________________DOB___/____/______Relationship____________

Secondary Insurance Company_______________________________I.D.#_______________________

Subscriber's Name______________________________DOB___/____/______Relationship____________

I authorize any holder of medical or other information about me to be released to my insurance company or the Social Security Administration needed for this or any related medical claim. I request payment of medical insurance benefits to Ocmulgee Physicians LLC. I understand that the charges I incur are my responsibility. I understand that it is my responsibility to know if my physician is in network with my plan. If my insurance company fails to make payment in a timely manner, I am responsible for this bill.

Signature____Date____/_____/_____

Patient Representative_______________________________________Relationship_________________

Patient Name________________________________ Date of Birth____________

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Patient Information

Past Medical History
Have you had any of the following conditions? If yes, please indicate when.

	N	Y	When		N	Y	When
Arthritis				**Liver Disease**			
Bowel Problems				**Lung Disease**			
Cancer				**Migraines/Headaches**			
Diabetes				**Osteoprosis/Osteopenia**			
Epilepsy/seizures				**Psychiatric Problems**			
Hearing/Ear Problems				**Stroke**			
Heart Problems				**Thyroid Problems**			
High Blood Pressure				**Other (specify)**			

Previous Hospitalizations/Surgeries
(List most recent First)

Year	Reason

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Telephone Number (478)746-0097
Fax Number (478)742-4051

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Patient Information

Allergies

Medication/Food	Reaction

Current Medications **Preferred Pharmacy_________________**

Please include all prescription medications, over-the-counter medications, vitamins, supplements, etc.

Medication	Dose	# Of Times Per Day?	How Long Have You Been Taking This?

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Patient Information

Social History

Marital Status	
Living Arrangement?	**Alone Immediate Family Group Significant Other**
Occupation	
Children?	**Son(s)____ Age(s)_________ Daughter(s)____ Age(s)_________**
Do You Smoke?	**No____ Yes____ How Much? ______**
Have You Ever Smoked?	**No____ Yes____ When Did You Quit? _______**
Do You Drink Alcohol?	**No____ Yes____**
What Do You Drink	**Beer____ Liquor____ Wine____ How Much/How often? ________**
Do You Drink Caffeine?	**No____ Yes____ How Much/How often? _____________________**
Do You Use Recreational Drugs?	**No____ Yes____ Specify __________________________**

Family History

	Father	**Mother**	**Father's Parents**	**Mother's Parents**	**Siblings**	**Children**
Living or deceased	L D	L D	L D	L D	L D	L D
Anemia						
Arthritis						
Asthma						
Bowel Problems						
Breathing Problems						
Cancer						
Depression						
Diabetes						
Epilepsy/Seizures						
Heart Problems						
High Blood Pressure						
High Cholesterol						
HIV/AIDS						
Jaundice						
Liver Disease						
Lung Disease						
Migraines						
Numbness/Weakness						
Psychiatric Problems						
Stroke						
Thyroid Problems						
Tuberculosis						

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Patient Information

Health Record

Most Recent:	Date	Doctor/Location
Physical		
Mammogram		
Pap Smear		
Bone Density		
Echo		
Stress Test		
Colonoscopy		
Upper Endoscopy		
Eye Exam		
Sleep Study		
Flu Vaccine		
Pneumonia Vaccine		
Shingle Vaccine		
Tetanus Vaccine		

Do You Exercise Routinely?	What Type?	How Often?
Are You On A Diet?	What Type?	For how long?
Do you Wear Your Seat Belt?	Yes	No
Any Fall(s) In The Last Year?	When?	Where?

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Medicare Requirement for Annual Wellness Visit
Current list of patient's providers and Suppliers

Type of Specialist	Provider Name

Print all suppliers from which you may receive supplies (i.e. Home Health Agency, Diabetes supplies)

Name of Supplier:	Reason:

Depression Screen
Over the last two weeks, have you felt down, depressed or hopeless? YES NO
Over the last two weeks, have you felt little interest or pleasure in doing things? YES NO

Hearing Loss Screen
Do you have trouble hearing the television or radio when others do not? YES NO
Do you have to strain or struggle to hear/understand conversations? YES NO

Function Screen
Do you need help preparing meals, transportation shopping, taking your medication, managing finances, or other activities of daily living? YES NO
Do you live alone? YES NO

Home Safety Screen
Does your home have throw rugs, poor lighting, or a slippery bathtub/shower? YES NO
Does your home have grab bars in bathrooms, handrails on stairs and steps? YES NO
Does your home have functioning smoke alarms? YES NO

Nutrition Screen
Are you on a special Diet? YES NO
(If yes)Why? ____

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Patient Information

Epworth Sleepiness Scale (ESS)

The following questionnaire will help you measure your general level of daytime sleepiness. You are to rate the chance that you would doze off or fall asleep during different routine daytime situations. Answers to the questions are rated on a reliable scale called the Epworth Sleepiness Scale (ESS). Each item is rated from 0 to 3, with 0 meaning you would never doze or fall asleep in a given situation, and 3 meaning there is a very high chance that you would doze or fall asleep in that situation.

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you haven't done some of the activities recently, think about how they would have affected you.

It is important that you circle a number (0 to 3) for EACH situation.

Situation	Chance of Dozing			
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place (theater/meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (with no alcohol)	0	1	2	3
In a car, while stopped in traffic	0	1	2	3

Total Score _________

Patient Name: ____ Date: ____________

Reference: Johns MW. A new method for measuring daytime sleepiness: The Epworth Sleepiness Scale. Sleep 1991; 14(6):540-5

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Patient Information

HIPAA-Privacy Policy

It is the policy of our practice that all physicians and staff members preserve the integrity and confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our entire practice have the necessary medical and PHI to provide our patients the highest quality of medical care possible. Patients should not be afraid to provide information to our practice, physicians, or staff members for purpose of treatment, payment, and healthcare procedures. Our HIPAA policy in its entirety can be obtained through out office at any time. Let us know if you would like to receive a copy prior to signing this consent.

Authorization

Please Initial _____ I understand HIPAA and its policies.

Please Initial _____ I authorize the release of medical information necessary to process insurance claims and to healthcare providers for treatment or care.

Please Initial _____I hereby acknowledge that Ocmulgee Physicians LLC will share my medical information, as permitted under federal law (HIPAA) and Georgia State law, with my healthcare providers through a health information exchange.

Prescription History Authorization

I, ______________________, authorize the review of my prescription history for reasons of evaluation and treatments.

Patient Confidentiality

Patient confidentiality is a top priority at Ocmulgee Physicians LLC. Therefore, it is important that you provide us with the following information to ensure there is not a violation of this policy.

In the event that I, _____________________, am unable to be reached, Ocmulgee Physicians LLC may leave my test results with the following: (check all that apply)

____ I may be reached at work. Telephone #_(____)_______-________
____ May leave normal results on answering machine/ voicemail at work.
____ May leave normal results on answering machine/ voicemail at home
____ May leave normal results on answering machine/ voicemail on cell phone
____ May leave all results on answering machine/ voicemail at home/ cell/ work.
____ Other, Describe ____
____

Signature_______________________________________ Date_________________

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Patient Information

Authorization To Release All Medical Records

Patient Name:_____________________________ Address:____

DOB:______________ ____

Phone Number:_(_____)______-_________

Patient Authorization

I understand that my medical records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug/alcohol abuse, mental illness, or psychiatric treatment.

___________ I give my specific authorization for these records to be released.

___________ If not, Initial the information that you **DO NOT** want released:

___ Drug/alcohol abuse/treatment ___ Sexually transmitted disease

___ HIV/AIDS diagnosis/treatment ___ Psychiatric diagnosis/ treatment

This authorization will automatically expire one year from date signed. You may revoke this consent at any time, except to the extent that action has already been taken. You do not have to sign this authorization in order to obtain treatment, payment or enrollment. You may revoke or terminate this authorization by submitting a written revocation to Ocmulgee Physicians. Information disclosed under this authorization may be disclosed again by the person/ organization to which it was sent. It may not be possible to ensure your right to protection of the privacy of this information once Ocmulgee Physicians discloses it to another party.

Signature____

Witness____

Date____

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Patient Information

Consent To Disclose Protected Health Information

I, __________________________, am granting permission for Dr. Alan Justice or his staff to allow the following people to have access to my:

______ Medical Records

______ Account Information

I understand that I may revoke this permission by completing a new form.

Name	Relationship	Phone Number

_____________________________________ ___________________
Patient Signature Date

Patient Name____________________________________ Date of Birth____________

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Patient Information

Patient Portal User Agreement

We are pleased to provide a Patient Portal in partnership with our electronic medical records provider, EClinicalWorks, for the exclusive use of established patients. The Patient Portal is designed to enhance patient-physician communication. All users must be established by a previous office visit.

We strive to keep all of the information in your records correct and complete. If you identify any discrepancy in your records, you agree to notify us immediately. Additionally, by using the Patient Portal, the user agrees to provide factual and correct information.

The Patient Portal provides access to the following services:
-Request Appointments
-Request Prescription refills
-View your medical records
-Receive educational material
-Send messages to clinical staff
-Receive health maintenance reminders

The Patient Portal is not intended to provide internet based diagnostic medical services. The following limitations also apply:

-No internet based triage and treatment requests. Diagnosis can only be made and treatment rendered after the patient is seen by the doctor or nurse practitioner.
-No emergent communication or services. Any emergent conditions should be handled by calling the office directly, going to an urgent care clinic, emergency room, or by calling 911 should the emergency be life threatening.
-No requests for narcotic/controlled medications will be accepted.
-No requests for new prescriptions or refills for conditions for which you are not being treated by our providers will be accepted.
-It may take up to 48 hours to receive a response to an email request. If you do not receive a response within 48 hours you should contact the office at (478)746-0097
-If you lose your password or username, you may request a new one through the web portal or in person at the office by providing valid identification.
-Always remember to log out and close your browser when you are finished accessing password protected Patient Portal services. This prevents someone else from accessing your personal information.

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Patient Information

You should never use a public computer to access the Patient Portal

This Patient Portal is provided as a courtesy to our patients. However, if abuse or negligent usage of the Patient Portal persists, we reserve the right, at our discretion, to terminate the Patient Portal offering, suspend user access and modify services available through the Patient Portal.

Our data is HIPAA compliant with high level encryption. While we believe that the IT infrastructure and data are safe and secure, it does not guarantee that unforeseen, adverse events cannot occur. To the extent possible, our office has undergone rigorous IT implementation and security standards exceeding industry recommendations.

Please read our HIPAA policy for information on how private health information is used in our office. If you do not recall having signed a HIPAA agreement, or need to reacquaint with the HIPAA policy, we will be happy to provide you with a copy.

Once you have signed the Patient Portal User Agreement and have provided our office with a legitimate email address that is secure, you will be given our system generated unique user identification and password, along with login instructions.

Patient Acknowledge and Agreement

I acknowledge that I have read and fully understand this consent form. I have been given risks and benefits of the Patient Portal and agree that I understand the risks associated with online communications between Ocmulgee Physicians LLC and myself, and consent to the conditions outlined herein. I acknowledge that using the Patient Portal is entirely voluntary and will not impact the quality of care I receive should I decide against using the Patient Portal. In addition, I agree to adhere to the policies set forth herein, as well as any instructions or guidelines that my physician may impose for online communications. I have been given an opportunity to ask questions related to this agreement and all of my questions have been answered.

Patient Name: ____________________________

Patient Signature: __________________________

Patient Email Address: ______________________

Date: _____________

☐ Check this box to decline participation in the Patient Portal & sign above

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Patient Information

GENERAL AUTHORIZATION FOR TREATMENT/CONTACT

I authorize physicians, nurse practitioners, mid wives and/or physician assistants of Ocmulgee Physicians LLC who may attend me, their assistants, including those employed by Ocmulgee Physicians LLC to provide the medical care, tests, procedures, drugs, blood and blood products, services and supplies considered advisable by my provider. These services may include pathology, radiology, emergency services and other special services ordered by my provider. In consenting to treatment, I have not relied on any statements as to results. I further authorize my provider to examine, use, store, and/or dispose of in any manner (except for organ donation and/or transplantation) any tissue, fluids or parts removed from my body. In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substance that are capable of transmitting disease and I am unable to consult timely with my physician prior to testing, I consent to limited testing to determine the presence, if any, of antibodies to hepatitis A, B, and C and HIV. _____________ (initials)

I consent and give permission to Ocmulgee Physicians LLC to photograph me for internal purposes of patient identification only. This photograph will not be used for marketing purposes._____________ (initials)

RELEASE AND ASSIGNMENT OF BENEFITS

I understand that payment is due at the time service is rendered. I hereby authorize the release of any medical information to (1) an insurance company through which I claim benefits and (2) any physician involved in my medical care. I realize the authorization allows Ocmulgee Physicians LLC to release any information to any of my insurers or physicians. I authorize and direct my insurers to pay directly to Ocmulgee Physicians LLC and/or its physicians any and all benefits up to the amount of my bill pertaining to all charges incurred. I assign to Ocmulgee Physicians LLC, including its affiliates, any and all benefits or proceeds, of any type whatsoever, to which I am entitled, with respect to the health care service(s) I receive, including but not limited to, the proceeds of any liability settlement or judgment being paid by or on behalf of a third-party and any benefits due from any third-party insurance policy. I direct that all such benefits be paid directly to Ocmulgee Physicians LLC and/or its affiliates, including its physicians, and applied to my account(s) until the account(s) is paid in full. I understand that I am personally responsible for any remaining fees. _____________ (initials)

Print Patient Name: ____ DOB: ______________________

Patient Signature: ____ Date: ______________________

Responsible Party Signature (if different): _____________________ Date: _______________________