NEW PATIENT INFORMATION

Date: ________________ (please print)

PATIENT'S LEGAL NAME:	**PREFERRED NAME:**	**DATE OF BIRTH:**
MALE / FEMAL (circle one):	**SSN (required):**	**MARITAL STATUS: M W D S**
STREET ADDRESS:	CITY / STATE / ZIP:	**HOME PHONE:**
		CELL PHONE:
PATIENT'S / PARENT'S EMPLOYER:	OCCUPATION:	**WORK PHONE:**
EMPLOYER'S ADDRESS:	CITY / STATE / ZIP:	EMAIL ADDRESS:

SPOUSE / PARENT'S NAME:	SSN:	SPOUSE / PARENT DATE OF BIRTH:
SPOUSE / PARENT'S EMPLOYER:	OCCUPATION:	BUSINESS PHONE: CELL PHONE:
EMPLOYER'S STREET ADDRESS:	CITY / STATE / ZIP:	SPOUSE / PARENT EMAIL:

EMERGENCY CONTACT NAME:	**EMERGENCY CONTACT PHONE:**	DRUG STORE PREFERENCE
REFERRED BY: **Dr.** ____________________________	***How did you hear about us?*** 1. phone book 5. family 2. sign 6. other 3. friend 4. ad	Have you or any immediate family member been treated by Dr. Conner before? Name: ________________________

PERSON RESPONSIBLE FOR PAYMENT:	STREET ADDRESS:	HOME PHONE:
PRIMARY INSURANCE:	POLICY HOLDER NAME / SSN / DOB:	POLICY #
SECONDARY INSURANCE:	POLICY HOLDER NAME / SSN / DOB:	POLICY #

Please read: ALL CHARGES ARE DUE AT THE TIME OF SERVICE. THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE. IT IS OUR POLICY THAT PROFESSIONAL SERVICES RENDERED IN THE OFFICE BE PAID AT THE TIME OF SERVICE. THERE WILL BE A 1.75% FINANCE CHARGE PER MONTH ON ACCOUNTS 90 DAYS PAST DUE. OUR OFFICE FILES INSURANCE FOR MOST PLANS INCLUDING BCBS, CHAMPUS, MEDICARE, AND MEDICAID. (IT IS THE PATIENT'S RESPONSIBILITY TO CHECK TO MAKE SURE OUR OFFICE PARTICIPATES IN YOUR INSURANCE NETWORK). CURRENTLY WE AR ENOT ACCEPTING NEW MEDICAID PATIENTS.

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I HEREBY AUTHORIZE F. GEOFFERY CONNER, M.D. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HERBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FO RMEDICAL SERVICES RENDERED TO MYSELF AND MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

SIGNATURE: ____ DATE: __________________________

Name: ____ DOB:________________ SEX: M / F
Address: ____
Phone: Home: _____________________ Cell: _______________________ Work: _______________
Pharmacy: _____________________________________ Email Address: ___________________________

SOCIAL HISTORY *(please circle one):*
Marital Status: S M D W Regular Exercise: Y / N Homosexual: Y / N
Illegal Drugs: Y / N Alcohol Use: Y / N If yes, how many drinks per week? _____ per month? _____
Tobacco use: Y / N Smokeless Tobacco: Y / N
How many packs per day _________ for how many years? _________
Former smoker: Number of years quit __________ (*how many packs per day _________ for how many years? _________)*

List **ALL** current medical problems:

List **ALL** past medical problems:

LIST ALL DRUG ALLERGIES *(including x-ray dye, etc.):*

List **ALL** current medications *(please include dosage and any over the counter medications including vitamins):*

FAMILY HISTORY *(please circle if a blood relative has had any of the following):*

1. Heart attacks / heart disease
2. Strokes
3. High blood pressure
4. Diabetes
5. Colon polyps
6. Cancer ________________
7. Allergies
8. Kidney Stones
9. Tuberculosis
10. AIDS
11. Mental Illness
12. Bleeding problems
13. Alcoholism
14. Asthma

Other: ___________________

	Age	Living	Deceased	Cause of Death	Illnesses
Father					
Mother					
Brother(s)					
Sister (s)					
Child(ren)					

List **ALL** past Surgeries *(please list type and date):*

HEALTH MAINTENANCE: Have you had any of the following tests in the past?
Colonoscopy: Y / N date: ________________
Pneumonia Vaccine: Y / N date: ___________
Treadmill Cardiac Screening: Y / N date: ___________
Cholesterol Screening: Y / N date: ________________
Mammogram: Y / N date: ________________
PAP Smear (if female): Y / N date: __________
Bone Density Testing: Y / N date: __________
PSA / Prostate Exam (if male): Y / N date: __________

FINANCIAL AND PRACTICE POLICIES

Please read and initial beside each item.

INITIALS	ITEM #	POLICY
	1	**Emergencies**: Our providers will make every effort to receive your calls and respond promptly in an emergency. If you do not receive an immediate response, please call 911 or go to the nearest emergency room.
	2	**Prescription Refills**: It is our policy that you should be responsible to know when your medications must be refilled at least a week before you run out. Medications are refilled only at the patient visit or when requested in advance through your pharmacy (this includes mail order prescriptions). **Phone calls for refills should be directed to your pharmacy.**
	3	**Sick Patients**: Patients with acute illnesses will be seen within 24 hours.
	4	**Information**: You agree to provide your correct name, current and correct address, home and cellular number, insurance information, social security number, driver's license, or picture identification at the time of registration or as requested by the practice at any time.
	5	**Financial Responsibility**: By these initials and your signature below, you accept financial responsibility for all charges for services rendered to you. If a minor or under guardianship, the parent or guardian accompanying the patient assumes this liability. ALL PAYMENTS ARE DUE AT THE TIME OF SERVICE.
	6	**Payment Methods**: We accept cash, check, visa, Master and Discover credit cards, and care credit.
	7	**Appointments**: Our office will schedule appointments as a common courtesy for patients and in consideration of your time. Minors must be accompanied by a parent or guardian to be seen in our office. We require a minimum of 24 hours' notice of cancellation as a courtesy to other patients seeking medical service. **A fee of $25 will be charged at our discretion for non-cancelled and missed appointments for established patients. New patients who fail to cancel will be billed $100. A pattern of non-cancelled missed appointments may result in discharge from the practice. If you are more than 15 minutes late, you will be rescheduled.**
	8	**Forms Fees**: Our practice charges for additional paperwork outside of the completion of the medical record. A $15 fee will be charged for forms that must be completed and signed by a doctor.
	9	**Medical Records:** The medical chart is property of the practice. However, copies of your pertinent information is available upon request. We request that you allow at least one-week notification when requesting a copy of your entire medical record.
	10	**Insurance Copayments, Deductibles, and Coinsurance:** Insurance companies do not pay all fees and may exclude certain services from coverage. It is your responsibility to understand your insurance plan. All copayments, deductibles, coinsurance or non-covered services are due at the time of service. If requested, and as a condition of service, you agree to sign an "advanced beneficiary notice" if we determine or question your insurance coverage. You accept responsibility for all such expenses even if your insurance company is billed as a courtesy.

	11	<u>**Usual and Customary**</u>: Some insurance plans may indicate that our fees are above "usual and customary". As a result, your plan may reduce our fee to an "allowed amount" before calculating. This practice does not recognize a specific carrier's use of these terms. As such, unless we have specifically contracted with the carrier, it is expected that you will be liable for the full fees.
	12	<u>**Slow Insurance Response:**</u> You agree that if your insurance company takes more than 60 days to respond to your insurance claim that we shall consider your services your financial responsibility and it will be your responsibility to see reimbursement from your insurance company. ***There will be a $50 refiling fee charged if we have to refile a claim due to receiving the wrong insurance cards from the patient.***
	13	<u>**Accident and Worker's Compensation:**</u> Although our office will be happy to treat your medical condition, if the cause is related to an auto or work-related accident, ***you will be required to pay the full fees at the time of your visit.***
	14	<u>**Statement Policy:**</u> Our office sends patient statements each month. Payments are due upon receipt of the statement. You understand that if we participate with your insurance company the sending of a statement may be delayed until your insurance company responds to a claim for services. Such a delay can take months. You understand that such a delay does not alter our policy of patient financial responsibility and you will be liable for all service fees. A late fee may be charged for patient balances with a minimum charge of $35.
	15	<u>**Collection and Bank Fees:**</u> Accounts more than 90 days old are subject to transfer to an outside collection agency. These agencies charge fees. You agree to be liable for all such collection expenses, legal fees, and court costs. In addition, banks charge for checks that do not clear or cannot be cashed. You agree to be liable for all such fees with a minimum charge of $35.
	16	<u>**Patient Discharge:**</u> The practice reserves the right to discharge a patient for any reason. Please note that discharge may occur for failure to meet your obligations under this document. In addition, because of care quality considerations, the practice may discharge you for failure to comply with treatment plans as outlined by your practitioner.
	17	<u>**Insurance Claims:**</u> If applicable, our office will submit insurance claims. You agree to allow our practice to "accept assignment" of benefits and receive payment directly from your insurance company. In the event your insurer sends payment for a claim from our office to you directly, you agree to remit payment in full for this claim.
	18	Our office contracts with several insurance companies, however, these contracts can change or we may drop out at any time without notice. **WE DO NOT PARTICIPATE WITH THE FOLLOWING CARRIERS:** BCBS Pathway / Pathway X, Amerigroup, and Ambetter.

I have read and understand the terms of this policy and by my initials and signature below, I attest that I fully understand each item and agree to the above terms.

Printed Name: ____ Date: _______________

Signature: ____

HIPAA Right of Access Form for Family Member / Friend

I, ____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: ____ ____

Relationship: ____ ____

Contact Information: ____
____

Health information to be disclosed upon the request of the person named above *(check either A or B).*

☐ A. Disclose my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing for all conditions) OR

☐ B. Disclose my health record, as above, BUT do not disclose the following (*check as appropriate*):
- ☐ Mental Health Records
- ☐ Communicable disease (including HIV and AIDS)
- ☐ Alcohol / Drug Abuse Treatment
- ☐ Other (*please specify*):
____
____

Form of Disclosure (*unless another format is mutually agreed upon between my provider and designee*):
- ☐ An electronic record or access through an online portal
- ☐ Hard Copy

This authorization shall be effective until (*check one*):
- ☐ All past, present, and future periods, OR
- ☐ Date or event: ____ unless I revoke it.

(NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing)

____ ________________________
Name of Individual Giving this Authorization | Date of Birth

____ ________________________
Signature of Individual Giving this Authorization | Today's Date

Note: HIPAA Authority for Right of Access: 45 C. F. R. § 164.524

Please fill out and sign:

Do you have a primary care physician? Yes _________ No _________

If so, please list name and address:

____

____

I understand and acknowledge that Dr Conner will be seeing me / my child for the express purpose and treatment of allergy and/or asthma related conditions. Any other medical problem encountered should be treated by my primary care physician.

____ _________________________

Signature Date

Please be aware that we do not participate with any lab benefit programs (i.e. LabOne, LabCorp, etc.). With the exception of a few specialty tests, all lab work is drawn at and billed through our office.

____ _________________________

Signature Date

The Allergy & Asthma Clinic, Acute Care Clinic, and Abednego Primary Care strive to maintain a pleasant and safe environment for its staff and patients. In order to accomplish this, we request that you agree to follow these rules of conduct while on the premises of the Allergy & Asthma Clinic, Acute Care Clinic, and Abednego Primary Care.

- Be respectful at all times to other patients and medical staff.
- Do not bring weapons of any type onto office premises.
- Refrain from any language that may be abusive or offensive to other patients or to the office staff.
- Refrain from any form of physical violence while on office premises.

____ _________________________

Signature Date

ALLERGY & ASTHMA CLINIC OF SE GA
ACUTE CARE CLNIC
ABEDNEGO PRIMARY CARE

PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

As required by the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

I have reviewed a copy of the Notice of Privacy Practices of the Allergy & Asthma Clinic / Acute Care Clinic / Abednego Primary Care on the date indicated below.

I understand that if any changes are made to this Notice of Privacy Practices, a revised copy of the Notice will be posted in the offices of the Allergy & Asthma Clinic / Acute Care Clinic / Abednego Primary Care.

I also understand that if I wish to receive a copy of this Notice of Privacy Practices or if I have any questions with regard to this Notice of Privacy Practices, I may ask the receptionist or contact:

Allergy & Asthma Clinic of SE GA
Acute Care Clinic
Abednego Primary Care
1608 Meadows Lane
Vidalia, GA 30474
P (912) 537-9488
F (912) 537-8951

____
Signature of Patient

____ ____________________
PRINT NAME DATE

THIS SPACE TO BE USED BY PRACTICE ONLY.
DATE ACKNOWLEDGEMENT DENIED BY PATIENT: __________________________

REASON DENIED BY PATIENT: ____

NAME OF PERSON REVIEWING DENIAL: __________________________________

TODAY'S DATE: ________________________

Welcome to the Allergy & Asthma Clinic, Acute Care Clinic, and Abednego Primary Care. We appreciate your confidence in choosing our office(s) for your medical care. In order to ensure we meet your expectations, please review the following information regarding our services and office policies.

We offer same day appointments for urgent medical problems for our established patients. Urgent problems are usually treated by our Nurse Practitioner/PA at the Acute Care Clinic. Calls for same day appointments must be before 4pm.

We are open 7 days a week, except on holidays, 7 am to 7pm M-F, 8 am to 3 pm on Saturday, and 1pm -5pm on Sunday. ***Saturday and Sunday are for urgent care only***.

You can reach Dr. Conner or the covering physician 24 hours a day by calling 912-535-5555 to have him paged. During office hours call 912-537-9488.

We provide many in-house medical services. These include:

- In-house CLIA Certified Lab
- Cardiac Stress Testing / Screening
- Pulmonary Function Testing
- Bone Density Scans
- Sonograms
- X-Rays
- Home Sleep Studies

Hospital care if needed for patients over 15 years of age is provided by Dr. Conner at Memorial Health Meadows in Vidalia, GA. We can also arrange for care to be provided at other hospitals upon request.

We ask that you bring all medications with you to every office visit. This helps ensure that your medical record is as accurate as possible.

When calling for a refill of a medication, please contact your pharmacy and they will call/fax our office. Refills are generally taken care of within 24 hours.

Messages left for the nurse are returned the same business day if left before 4pm. Any messages left after 4pm will be returned the next business day. If the problem is emergent, please inform the receptionist also the nurse can be alerted.

If you have not been seen in the office within a 3-year time span, we will have to schedule you as a new patient. We also may not be able to guarantee a same day appointment if it has been over 3 years since your last visit.

While we do offer in-house laboratory services, we do not perform lab work ordered by other physicians. Orders from other physicians can be taken to local facilities such as as Doctor's Lab, Quest, or the hospital.

We contact patients for call-backs on lab results and test results by either phone or text messaging. Please inform us if you would prefer a different method of communication.

I have read and have been fully explained and understand the above stated policies.

______________________________ __________________
Signature Date

______________________________ __________________
Witness Date