Vidalia
INTERNAL MEDICINE
Compassionate care for our communtiy

Dr. Poole will establish an individualized plan of care at the first visit. Subsequent visits will alternate between Dr. Poole and mid level providers (Physician Assistant/Nurse Practioner).

☐ New Patient Registration Packet

(Contains the following)

- Demographic Information
- Insurance Information
- Authorization to Release Medical Information
- **List of Medications from **Pharmacy** ***(****appointment will be* ***delayed)***
- Past Medical History / Family History (PMH/FH)
- Authorization for Release of Medical Records
- Privacy Notice Acknowledgment
- Office and Conduct Policies

☐ Copy of Drivers License or ID

☐ Copy of Health Insurance Card

☐ **Medications** - Bring a current list of Medicines from you **Pharmacy**

- Bring all medications to your first appointment.
- Bring insurance card to each appointment
- If you require pain management, mental health or behavior health treatment/medications and are not currently being treated by a specialist, we can send the appropriate referral.

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DATE:_____ (912) 537-2200

First Name _____MI_____ Last Name_____ Preferred Name_____

SS#_____ Date of Birth_____/_____/_____ □MALE □FEMALE

Address_____ Race_____

City _____ST_____ZIP_____ Ethnicity: □Hispanic/Latino □NonHispanic/Latino

PHONE: HOME _____ □Single □Married □Widowed □Divorced

CELL _____ Spouse Name_____

Email _____ Spouse Phone_____

EMPLOYER_____

WORK PHONE _____ OCCUPATION_____

*__Appointment Reminder__: confirm my appointment by __Text Message__ or __Phone Call__ at __(___)___-_____

(Circle preferred)

__Emergency Contact__ _____

Relationship_____Phone_____

__Pharmacy__ _____ __Preferred Lab__ _____

INSURANCE INFORMATION

PRIMARY

Insurance Company _____

Policy #_____Group#_____

Name of Insured:_____

Relationship to Insured _____

Date of Birth _____ SS#_____

SECONDARY

Insurance Company _____

Policy #_____Group#_____

Name of Insured:_____

Relationship to Insured _____

Date of Birth _____ SS#_____

Authorization to Release Medical Information

NAME	RELATIONSHIP	PHONE NUMBER

__Signature:__ _____

MEDICATIONS, Vitamins and Supplements	Dosage	Frequency

(Your pharmacy can generate a list)

MEDICATION ALLERGIES: _____

_____

SURGICAL HISTORY	Date	Surgeon

DATE OF LAST COLONOSCOPY _____/_____/_____

MENSTRUAL HISTORY (WOMEN ONLY):

AGE OF ONSET_____ DATE OF LAST PERIOD _____/_____/_____ ARE PERIODS REGULAR_____

DATE OF LAST PAP SMEAR_____/_____/_____ NUMBER OF PREGNANCIES_____ MISCARRIAGES_____ CHILDREN_____

DATE OF LAST MAMMOGRAM_____/_____/_____

SOCIAL HISTORY:

PRESENT OR PAST **TOBACCO** USE ? YES OR NO

SMOKE YES OR NO AMOUNT_____ HOW LONG_____ WHEN STOPPED_____

SMOKELESS YES OR NO AMOUNT_____ HOW LONG_____ WHEN STOPPED_____

DO YOU DRINK ALCOHOLIC BEVERAGES? YES OR NO TYPE_____ AMOUNT_____ HOW LONG_____

DO YOU CONSUME CAFFEINE DAILY? YES OR NO TYPE_____ AMOUNT_____ HOW LONG_____

DRUG USE ? PRESENTLY PAST NEVER TYPE_____

IMMUNIZATIONS AND YEAR THAT YOU LAST HAD THEM:

PNEUMONIA _____/_____/_____ SHINGLES _____/_____/_____ TETANUS _____/_____/_____

INFLUENZA _____/_____/_____ PERTUSSIS _____/_____/_____ DIPHTHERIA _____/_____/_____

Previous Primary Care Physician _____

PMH / FH

PLEASE CHECK ALL THAT APPLY	***Yourself***	Father	Mother	Father's Parents	Mother's Parents	Siblings
Heart Disease						
Heart Palpitations						
Heart Murmur						
Atrial Fibrillation						
High Blood Pressure						
Diabetes						
Glaucoma						
Kidney Disease						
Kidney Stones						
Stroke						
Cancer						
Abnormal Bleeding						
Anemia						
Arthritis						
Asthma						
Tuberculosis						
Thyroid Disease						
Mental Illness						
Epilepsy/Convulsions						
Depression						
GI Disorder						
Osteoporosis						
OTHER						
OTHER						
OTHER						

210 Mose Coleman Drive
Vidalia, GA 30474
912-537-2200 Office
912-537-2260 Fax

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize the release of my medical records pertaining to:

- o All medical treatment **From** _____ **To** _____
- o Laboratory tests **(Date)** **(Date)**
- o Specific treatment

The purpose for requesting my medical records: _____

I understand that my records may include information relating to Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV (Human Immunodeficiency Virus). Also, any reference of psychiatric care, treatment for alcohol and/or drug abuse that may be in my medical record.

_____
Facility/ Physician Medical Records Are Being Released From

The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____
Print Patient / Legal Guardian Name **Patient Date of Birth**

_____ _____
Patient / Legal Guardian Signature **Date**

Witness: _____

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HIPAA 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 it carefully. If you have any questions about this notice, please contact our office at 912.537.2200

OUR OBLIGATIONS

We are required by law to:

- Maintain the privacy of Protected Health Information (PHI)
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

PHI includes information that we create or receive about your past, present, or future health or condition, the provision of health care to you, or the payment for health care provided to you. In general, we may not use or share anymore PHI than is necessary to accomplish our purpose.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our Practice Administrator.

- **Treatment**: We may use and disclose PHI for your treatment and to provide you with treatment-related health care services. For example, we may disclose PHI to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

- **Payment**: We may use and disclose PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may share PHI with your health plan to obtain approval for the health care services we provided to you. We may also share PHI with billing companies and companies that process our health care claims.

- **Health Care Operations**: We may use and disclose PHI for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the care you receive is of the highest quality. We may also share information with our accountants, attorneys and others in order to make sure we are complying with the laws that affect us.

OTHER USES OF PHI

- **Reports required by law**: We may report PHI when the law requires us to give information to government agencies and law enforcement about victims' of abuse, neglect, or domestic violence; when dealing with gunshot and other wounds, or when required in a legal proceeding.

- **Public health**: We may report PHI about births, deaths, and other diseases to government officials in charge of collecting that information. We may provide PHI relating to death to coroners, medical examiners, and funeral directors.

- **Health oversight**: We may report PHI to assist the government when it investigates or inspects a health care provider or organization.

- **Organ Donation**: We may notify organ banks to assist them in organ, eye, or tissue donation and transplants.

- **Research**: We may use PHI in order to conduct medical research.

- **To avoid harm**: We may report PHI to law enforcement, in order to avoid a serious threat to the health or safety of a person or the public.

- **Other government functions**: We may report PHI for certain military and veterans' activities, national security and intelligence purposes, protective services for the President of the United States, or correctional facility situations.

- **Workers' compensation**: We may report PHI in order to comply with workers' compensation laws.

- **Appointment reminders and health-related benefits or services**: We may use health information to give you appointment reminders; or give you information about treatment choices or other health care services or benefits we offer.

- **Inmates or individuals in custody**: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information to the correctional institution or law enforcement official. This release would be made necessary if: 1) for the institution to provide you with health care: 2) to protect your health and safety or the health and safety of others: 3) for the safety and security of the correctional institution.

Your Rights

You have the following rights regarding health information we have about you:

- **Your rights to request limits on our use of PHI**: You may ask that we limit how we use and share you PHI. We will consider your request but are not legally required to agree to it. If we agree to your request, we will follow your limits, except in emergency situations. You cannot limit the uses and reports that we are legally required or allowed to make. To request a restriction, you must make your request in writing to the Practice Administrator.

- **Right to Request Confidential Communication**: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communication, you must make your request in writing to the Practice Administrator. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

- **Your right to view and get a copy of your PHI**: You may view or obtain a copy

of your PHI (except for mental health notes). Your request must be in writing. We will reply to you within 30 days of your request. If you request a copy of your PHI, we may charge a fee. Instead of providing the PHI you requested, we may offer to give you a summary or explanation of the PHI, as long as you agree to that and to the cost in advance.

- **Your rights to a list of the reports we have made**: You have the right to get a list of the parties to whom we have reported you PHI. The list will not include reports for treatment, payment, or health care operation; reports you have previously authorized: reports made directly to you or to your family; reports made for national security purposes; reports to corrections or law enforcement personnel; or reports made before April 14, 2003.

- **We will respond to your request within 60 days**: we will include the reports made in the last six years unless you request a shorter time. The list will include the date of each report, the identity of the person (s) receiving the report, the type of information reported, and the reason for the report.

- **We will not charge you for the list**: If you make more than one request in the same year, however, we may charge you a fee for each additional request. For a list, you must make a request in writing to the Practice Administrator.

- **Your right to correct or update you PHI**: If you feel that there is a mistake in your PHI, or that important information is

missing, you may request a correction. Your request must be in writing and include a reason for the request. Your request must be made to the Practice Administrator. *We will respond within 60 days of your request. We may deny your request if the PHI is, 1) correct and complete, 2) not created by us, 3) not allowed to be shared with you, or 4) not in our records. If we deny your request, we will inform you of the reason for the denial. You may then file a written statement of disagreement, or you may ask that your original request and our denial be attached to all future reports of your PHI.*

If we agree to honor your request, we will change your PHI, inform you of the change, and tell any others that need to know about the change to your PHI.

- **Your right to a paper copy of this notice**: You can ask us for a copy of this notice at any time.

- **Person to contact for information about this notice or to file a complaint about our privacy practices**: If you have any questions about this notice, wish to file a complaint about our privacy practices, feel that we may have violated your privacy rights, or disagree with a decision we made about access to your PHI, please contact our Practice Administrator. You may also send a written complaint to the Secretary, U.S. Department of Health and Human Services, 2003 Independence Avenue, S.W., Washington, D.C. 20201. Your complaint will not alter or affect the care we provide to you.

- **Effective date of this notice**: this notice is in effect as of September, 2012

CONSENT TO TREAT

I hereby consent and authorize the performance of all appropriate procedures and courses of treatment, the administration of all anesthetics, and any and all medications which in the judgment of my provider may be considered necessary or advisable for my diagnosis and/or treatment.

FINANCIAL RESPONSIBILITY

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at Vidalia Internal Medicine. I am responsible for any applicable deductible, co-insurance or co-payments prior to the provision of services. Vidalia Internal Medicine will provide me with an estimate of my total financial responsibility and the date by which this amount must be paid in full. In the event my care exceeds the amount of the estimate, I will be financially responsible for the balance. I further understand that such payment is not contingent on any insurance, settlement or judgment payment.

Vidalia Internal Medicine may file a claim for payment with my insurance company as required by contractual agreement. If the insurance company fails to pay Vidalia Internal Medicine in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts owed to Vidalia Internal Medicine**. Should the account be referred to a collection agency or attorney for collection, the undersigned shall pay all costs of collection, including but not limited to court cost and 15% attorney's fee.**

RESPONSIBILITY TO PROVIDE PROOF OF INSURANCE

I understand that it is **my responsibility** to provide Vidalia Internal Medicine with a copy of my **current insurance** card. If I do not have insurance, I will be considered a Private Pay (or Self Pay) patient and I am financially responsible for the total amount of the services provided. **I will notify Vidalia Internal Medicine immediately upon any change in my insurance**.

ASSIGNMENT OF BENEFITS

I hereby authorize and assign all payments and/or insurance benefits for medical services and procedures rendered to patient, directly to **Vidalia Internal Medicine**. I hereby authorize Vidalia Internal Medicine to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by my insurance plan.

INSURANCE WAIVER , NON-COVERED SERVICES WAIVER and OUTSIDE LAB SERVICES

I understand that if I do not have a copy of a current insurance card and valid referral, if required, Vidalia Internal Medicine is not obligated to see me. Without proof of insurance, I agree to pay the total cost in advance. I agree that neither Vidalia Internal Medicine nor I will file a claim for the visit. I will be required to pay the total cost of the visit in advance. In addition, there may be a service I desire, suggested or provided that is not covered under my insurance plan ("Non-Covered Services"); I understand I must pay for "Non-Covered" services. If feasible, a waiver will be completed for each "Private Pay" visit or "Non-Covered Service." I understand services sent to an outside lab are billed to my insurance or me by the lab and I will receive a separate invoice from the lab.

ANNUAL EXAMS (Including Medicare Annual Visits)

Annual Wellness Exams are preventive visits and are very important in developing a personal health strategy. Most Insurance companies allow one annual wellness exam per year. **All patients of Vidalia Internal Medicine must have their Annual Wellness Exam performed at this facility each year.** I understand this is very important as Vidalia Internal Medicine strives to develop a strategy to manage my long term health. I realize this strategy can help maintain or improve my overall health which in turn may reduce "sick visits" and hospitalization.

Therefore, Annual exams do not include "sick" problems I may be having – as insurance companies classify these visits as "sick visits." If I am experiencing problems, the office may be required to change the visit type per insurance requirements and reschedule the Annual Wellness Exam.

ADDITIONAL INFORMATION

Vidalia Internal Medicine accepts payments in: Cash, Check, Debit and Credit Cards.

I understand additional charges are applied to my account for any **returned checks** used to pay on my account, for certified letters sent to me for collection on my account and collection agency fees. I may also be charged if I do not cancel my scheduled appointment, for not paying my co-pay and/or co-insurance or patient responsibility including deductible at the time of service, for telephone management services, for educational materials, for payment agreements which extend beyond 3 months, and for other administrative expenses not covered by my insurance plan.

In the event I receive payment from my insurance carrier, I agree to endorse any payment due for services rendered to Vidalia Internal Medicine.

This office utilizes the services of physician assistant/nurse practitioner. Patients will alternate appointments between the physician and physician assistant/nurse practitioner so each provider will be familiar with all patients. Appointments may be moved to another provider in the event of an emergency or to reduce a prolonged wait time.

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Patient Name:_____ Date:_____

OFFICE POLICIES

SCHEDULING APPOINTMENTS

Our front office staff may need to question you as the reasons you need to be seen in order to give you an accurate appointment length. Please answer them accurately to help us keep our physician's schedule running on time and to minimize wait times.
If you are more than 15 minutes late for an appointment, you may be asked to reschedule.

Initials_____

MISSED APPOINTMENTS

Our office does charge a **$25 fee** for missed appointments without a phone call to cancel at least 24 hours before your appointment time. If you are charged, this must be paid in full prior to being seen again in our office. After three missed/rescheduled appointments, you may be discharged for medical noncompliance.

Initials_____

PRESCRIPTION REFILLS

- If your prescriptions are filled at a pharmacy, **PLEASE CALL YOUR PHARMACY FIRST** and ask them to request a refill. This is the most efficient method to refill prescriptions. You may be billed **$25** if you do not first request the refill through the pharmacy.
- Allow two days for the refill request to be processed.
- Appointments are the BEST TIME to discuss upcoming refills.
- Please bring **ALL** medications to **EVERY** appointment.
- **DO NOT WAIT UNTIL YOU ARE OUT OF MEDICATION TO CALL.**

Initials_____

RETURNED CHECKS

All returned checks will incur a **$35** billing fee. The patient will be responsible to pay this in full before being seen again in our office.

Refunds

All money will be refunded in form of check. Allow up to ten business days for all refunds.

Initials_____

LAB/TEST RESULTS

If you have not heard from our office within 2 weeks of having **labs** or **tests** , please call our office.

Initials_____

METHOD OF CONTACT

Facebook and text messages cannot be consistently monitored.
Please direct all correspondence to our office (912) 537-2200 Initials_____
All after hour **emergencies** should call **911**

Physician Assistant/Nurse Practitioner

This office utilizes the services of physician assistant/nurse practitioner. Patients will alternate appointments between the physician and physician assistant/nurse practitioner so each provider will be familiar with all patients. Appointments may be moved to another provider in the event of an emergency or to reduce a prolonged wait time.

Initials_____

CONDUCT

Incidents of inappropriate conduct will be dealt with for the safety and well-being of patients, employees, physicians, and others in the office so that this office can perform in an orderly manner. Patients are responsible for all individuals accompanying them. For purposes of this policy, examples of inappropriate conduct include, but are not limited to the following:

- Profanity, vulgar or similarly offensive language, while speaking with or in the presences of nurses, staff, physicians, patients, or guests;
- Threatening or abusive language directed at or in the presence of nurses, staff, physicians, other patients, or guests (e.g. belittling, berating, and/or intimidating another individual);
- Degrading or demeaning comments or jesters regarding nurses, patients, staff, physicians, guests, or office policies;
- Inappropriate physical contact or harassment;
- Derogatory comments about nurses, staff, physicians, policies, or quality of care being provided;

Please let the physician know if you feel you were mistreated.

Patients will be asked to leave immediately and maybe dismissed from this practice if they, or anyone accompanying them, are in violation of any part of this policy.

Initials_____

HOW DID YOU HEAR ABOUT US? (circle)

Family / Friend • TV Advertisement • Radio Advertisement • Magazine Advertisement • Phone Book • **Other _____**

I acknowledge that I have had the opportunity to read and review a copy of **Vidalia Internal Medicine's HIPPA Privacy Notice, Terms and Conditions, and Office Policies**. I understand that I am responsible to read the HIPPA Notice and notify Vidalia Internal Medicine, in writing, of any request for restrictions in the use or disclosure of my individually identifiable health information. I understand the HIPPA Notice includes electronic access to my medication history. Vidalia Internal Medicine has the right to revise this Notice at any time. Vidalia Internal Medicine will provide me with a copy of its most recent Notice upon my request.

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Patient Printed Name_____ Date of Birth:_____

Patient Signature: _____ Date signed:_____

Parent, Guardian or Legal Representative Printed Name:_____

Signature:_____ Date signed:_____