Middle Georgia Medical Associates
1110 Commerce Drive Suite 108
Greensboro, GA 30642
Phone: (706) 999-0243
Fax: (706) 999-0245

Please Fill Out Completely:

Patient's Last Name					First Name			MI
Social Security Number	Date of Birth	Age	Gender	Race	Marital Status	Ethnicity (Circle one): Latino Non-Latino Other		Language
Address (Street, Route, Apt. No., etc.)					City		State	Zip Code
Home Phone	Cell Number				Cell phone carrier (ex. Verizon)			
Email Address					Best way to contact (Circle one): Home Phone Cell Phone Email Letter			
Employed by								
Business Phone	Employer's Address				City		State	Zip Code

SPOUSE/GUARDIAN (If patient is married, give spouse information. If patient is a child, give parent information.)

Name	Address		City	State	Zip Code
Home Phone	Social Security	Date of Birth	Relationship to Patient		
Employed by		Business Phone			
Employer's Address			City	State	Zip Code
Emergency Contact (Friend or relative not at Patient's address who can get a message to you.)				Daytime Phone	

St. Mary's Medical Group will use the email provided above to enroll you into our patient portal. You will receive an email to complete the enrollment process.
Is the email given above used by another member of your household or family? If yes, by whom: ______________________________

Are you a currently patient at any other St. Mary's Medical Group Location? If so, which locations: ______________________________

____

INSURANCE INFORMATION **(Please provide your insurance card(s) at the time of visit)**

____ ____________________
Patient or Guardian Signature Date

MIDDLE GEORGIA MEDICAL ASSOCIATES
OWNED AND OPERATED BY ST. MARY'S MEDICAL GROUP, INC.
A SUBSIDIARY OF ST. MARY'S HEALTH CARE SYSTEM, INC.
("SMMG")

CONSENT TO TREATMENT

I hereby authorize and consent to such care, examinations and treatments including, but not limited to, any medical care or treatment, examinations, diagnostic procedures, and the furnishing of such supplies in connection with or relating to treatment as are necessary or desirable in the judgment of the treating physician.

FINANCIAL AGREEMENT

I hereby assume full responsibility for all charges incurred for professional services rendered by SMMG physicians. I agree that in return for the services provided to me, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to the above mentioned medical practice for payment. If any account is sent to collections, I agree to pay collection expenses.

ASSIGNMENT OF PAYMENT OF BENEFITS

In consideration of SMMG advancing or extending credit to me for my care, I hereby assign and transfer to SMMG all benefits and payments now due and payable or to become due and payable to me under any insurance policy or policies, under any replacement policies thereof, under any self-insurance program, or under any other benefit plan. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

I request payment of authorized Medicare benefits for me, or on my behalf, for any services furnished to me by or in SMMG, including physician services.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, the undersigned, hereby authorize SMMG or their representatives to release any of my medical information, protected health information or related information pertaining to this period of treatment, including AIDS Confidential Information and psychiatric information, that may be requested by any physician, provider, hospital, healthcare facility, any insurer or third party payor with whom I have coverage, my employer, or any public agency which may be assisting in payment of my care. I authorize SMMG to release to the Social Security Administration, Department of Medical Assistance, their intermediaries or carriers, or to review organizations, any information about me as needed for this or a related Medicare, Medicaid, or Tricare claim, including medical information relating to my treatment. I understand that health care services may be subject to review by review organizations as well

I HAVE READ THE FOREGOING CONSENT TO TREATMENT, FINANCIAL AGREEMENT, ASSIGNMENT OF PAYMENT OF BENEFITS, AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION. I AM AWARE OF THE CONTENTS OF EACH AND FULLY UNDERSTAND EACH.

I ACKNOWLEDGE THAT I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES OF ST. MARY'S HEALTH CARE SYSTEM, INC.

IN WITNESS WHEREOF, I HAVE PLACED MY HAND AND AFFIXED MY SEAL AS OF THE DATE INDICATED BELOW.

______________________________	______________________
Patient Name (Print)	Patient Date of Birth
______________________________	______________________
Patient or Guardian Signature	Date

I have agreed to let certain individuals participate in discussions and decisions related to my health care. I thereby give permission for Middle Georgia Medical Associates owned and operated by St. Mary's Medical Group, Inc. a subsidiary of ST. MARY'S HEALTH CARE SYSTEM and Doctor ____________________ to discuss my personal health care information with the following individual(s).

Name/Relationship _______________________________ Phone Number _________________

Name/Relationship _______________________________ Phone Number _________________

Name/Relationship _______________________________ Phone Number _________________

Conditions for Disclosure (check all that apply):

☐ The Clinic may disclose my personal health information to the individual(s) above **only** in my presence.

☐ Unless indicated otherwise, the Clinic may disclose my personal health information to the individual(s) above in my presence and when I am not physically present, including disclosures by telephone, facsimile, e-mail or regular mail.

☐ Other conditions of disclosure: ____

____

____

I understand that this consent may be revoked by me at any time by written notice to our office.

Patient signature: _________________________________ Date: _______________

Legal Representative: ______________________________ Date: _______________

Reason for Representative: ____

____

FCA: 06/03

Some or all of the health care professionals performing services in this Health Care System are independent contractors and are not hospital agents or employees. Independent contractors are responsible for their own actions and the Health Care System shall not be liable for the acts or omissions of any such independent contractors. O.C.G.A. 51-1-29.5(d)

Consent For Disclosure to Family Member and/or Personal Representative for Middle Georgia Medical Associates And St. Mary's Health Care System, Inc.

Patient Name _________________________
Address: _____________________________
____
Date of Birth: ________________________
SSN# ________________________________
Telephone # __________________________

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Authorization for Release of Medical Information

Patient: ____ **Date of Birth:** ______________________
(First) (Last)

I authorize the use or disclosure of the above-named patient's protected health information as described below.

I hereby authorize ____ **to release the information.**

For the purpose of: ____

Please check the type of Record to be Released

☐ **Complete Health Record**

☐ **ER Record**
☐ **History and Physical**
☐ **Discharge Summary**
☐ **Consultation Report**
☐ **Operative Report**
☐ **Nursing Documentation**

☐ **Office Notes**
☐ **Most Recent Lab Work (BMP, CMP, Lipids, LFTs)**
☐ **EKG**
☐ **Chest X-Ray Report**
☐ **Exercise Stress Test Results**

☐ **Echocardiogram Results**
☐ **Nuclear stress Test Results**
☐ **CT Scan Results**
☐ **Carotid/Vascular Studies**
☐ **Other as Specified:** ______
____
____

I understand that information in my health record may include information relating to Confidential Information and may include mental health, HIV/AIDS diagnosis, alcohol and drug use information and I also authorize the release of this information.

I understand this authorization may be revoked by me at any time. This must be in writing to the Office Manager. This would not apply to information that has already been release prior to my written revocation.

I understand that information disclosed under this authorization may be subject to re-disclosure by the recipient of such information and the information may no longer be protected under the terms of this authorization or by federal privacy laws.

I understand I may refuse to sign the authorization.

____ **Date:** _____/______/________
Patient Signature

____ **Date:** _____/______/________
Printed Name of Legal Representative

If signed by Legal Representative please provide the following:
Relationship to patient: ______________________________
Authority to sign on Behalf of the Patient: ☐ **Custodial Parent** ☐ **Durable Power of Attorney for Healthcare**
☐ **Other, Please describe:** ________________________________

Records may be faxed and/or mailed to the fax number and the address provided above.

Middle Georgia Medical Associates
St. Mary's Medical Group

Patient Name:______________________________ Birth Date: ____/____/_____ Date:_______________

Describe your main problem today: ________________________________ Allergies: _________________________

Where is your problem located? ___________________________________

How severe is your problem? ____________________________________

How long have you had this problem? ______________________________

When does this problem occur? __________________________________

What other things happen with this problem? ________________________

____

List previous hospitalizations/surgeries/serious injuries and when?

____

____

____

Date of last: Mammogram __________________________

Colonoscopy ___________________________

Pneumovax ____________________________

Monthly self breast exam? ☐ No ☐ Yes
Form of regular exercise? ☐ No ☐ Yes ____________
Seat belt use? ☐ No ☐ Yes

Social History:
Martial Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow(ed)

Use of Alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily__________

Use of Tobacco: ☐ Never ☐ Previous but quit ☐ Current packs per day ____

Use of Drugs: ☐ Never ☐ Type/frequency________________

Excessive exposure at home or work to: ☐ Fumes ☐ Dust ☐ Solvents ☐ Noise

Occupation: _______________________________________

Family Medical History:

	Age	Disease	If Deceased, cause of death
Father	_____	____________________	____________________
Mother	_____	____________________	____________________
Siblings	_____	____________________	____________________
	_____	____________________	____________________
Spouse	_____	____________________	____________________
Children	_____	____________________	____________________
	_____	____________________	____________________

Have you ever had the following?

Thyroid disease ……………. yes no
Diabetes …………….......... yes no
Hypertension ………………. yes no
Cancer ……........................ yes no
Stroke ………………………. yes no
Heart trouble ………………. yes no
Arthritis or gout …………… yes no
Convulsions ……………….. yes no
Bleeding Tendency ……….. yes no
Acute infections ……………. yes no
Sexually transmitted disease … yes no
Hereditary defects …………… yes no

List medications you are currently taking including nonprescription or herbals

1)__________________________

2)__________________________

3)__________________________

4)__________________________

5)__________________________

6)__________________________

7)__________________________

8)__________________________

9)__________________________

10)_________________________

Middle Georgia Medical Associates
St. Mary's Medical Group

Patient Name:________________________________ Date:_________________

GENERAL		
Fever	NO	YES
Chills	NO	YES
Change in Appetite	NO	YES
Fatigue	NO	YES
Weight loss	NO	YES
Weight gain	NO	YES
EYES		
double vision	NO	YES
blurred vision	NO	YES
change in vision	NO	YES
ENT		
Decreased hearing	NO	YES
Difficulty swallowing	NO	YES
Sore throat	NO	YES
Voice Change	NO	YES
Sinus problems	NO	YES
CARDIOVASCULAR		
Chest pain or Discomfort	NO	YES
Racing/skipping heart beats	NO	YES
Shortness of breath with exertion	NO	YES
Swelling -feet,ankles, hands	NO	YES
Leg pain with exertion	NO	YES
Varicose Veins	NO	YES
RESPIRATORY		
Sleep disturbance due to breathing	NO	YES
Cough	NO	YES
Shortness of breath	NO	YES
Wheezing	NO	YES
Excessive Snoring	NO	YES
FEMALE	N/A	
Breast Pain	NO	YES
Breast Lump	NO	YES
Breast discharge	NO	YES
Pain with periods	NO	YES
Irregular periods	NO	YES
Vaginal discharge	NO	YES
GASTROINTESTINAL		
Indigestion/heartburn	NO	YES
Nausea	NO	YES
Vomiting	NO	YES
Abdominal Pain	NO	YES
Diarrhea	NO	YES
Change in bowel habits	NO	YES
Dark tarry stools	NO	YES
Bloody stools	NO	YES

GENITOURINARY		
Dysuria	NO	YES
Hematuria	NO	YES
Urinary Frequency	NO	YES
Urinary Hesitancy	NO	YES
Nocturia	NO	YES
Incontinence	NO	YES
Decreased Libido	NO	YES
Erectile dysfunction	NO	YES
Testicular pain	NO	YES
MUSCULOSKELETAL		
Joint Pain	NO	YES
Joint Swelling	NO	YES
Muscle Aches	NO	YES
DERMATOLOGIC		
Suspicious lesions	NO	YES
Itching	NO	YES
Rash	NO	YES
Dry skin	NO	YES
NEUROLOGICAL		
Difficulty with concentration	NO	YES
Headaches	NO	YES
Falling Down	NO	YES
Weakness	NO	YES
Tremors	NO	YES
Memory Loss	NO	YES
Numbness/tingling	NO	YES
Lightheadedness	NO	YES
Vertigo	NO	YES
PSYCHIATRIC		
Anxiety	NO	YES
Depression	NO	YES
Sleep Problems	NO	YES
ENDOCRINE		
Cold Intolerance	NO	YES
Heat Intolerance	NO	YES
Excessive Urination	NO	YES
Excessive thirst	NO	YES
HEMETOLOGICAL		
Enlarged Lymph Nodes	NO	YES
Bleeding	NO	YES
Abnormal bruising	NO	YES
Anemia	NO	YES
ALLERGY		
Food Allergies	NO	YES
Year-Round Allergies	NO	YES
Hives or Rash	NO	YES
Seasonal Allergies	NO	YES

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eRx Consent

ePrescribing is a federally mandated initiative that requires all physicians to prescribe medications electronically beginning in 2011.

ePrescribing software sends your prescriptions over the internet to your pharmacy in a safe, secure way through the same technology used by credit card companies. This helps protect the privacy of your personal information.

ePrescribing software also lets your physician see important information like drug interactions and your prescription history.

The benefit to you is:

- Less confusion over handwritten prescriptions or unclear phone calls.
- Reduced possibility of medical errors.
- Less chance of adverse drug reactions.
- Fewer trips to drop off at the pharmacy.
- A safer, faster, easier way to get your prescription filled.

Patient Consent:

I agree that Middle Georgia Medical Associates may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

____
Patient Signature (or legal guardian)

____
Print Patients Name

____
Primary Pharmacy Name

____
Pharmacy Street and City

____
Secondary Pharmacy if applicable

____
Pharmacy Street and City

____
Date

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Dear Patient:

It has come to our attention that there is confusion concerning annual preventive care visits and/or annual Medicare wellness visits that occur on the same day as a follow-up office visit. Follow-up visits can be for your chronic medical problems and/or new problems or concerns that have arisen since your last appointment here in our office.

- Your annual wellness visit, and/or preventive care visit includes: a review of your overall health and recommended screening procedures (such as mammograms, colonoscopies and certain lab tests) and preventive measures (such as vaccinations) that may be beneficial in maintaining overall good health.
- The office visit includes: review of new and/or acute problems or concerns and chronic medical conditions such as hypertension and diabetes.

If you have a new medical problem that needs evaluation and requires your physician to order specific tests and/or medications, this must be billed as a separate office visit. If you have chronic medical conditions that require supervision and surveillance and ordering of specific tests and medications, this is not included in the wellness visit and must be billed as a separate office visit. **As a benefit to you, we offer you the option to have both of these visits done on the same day.** This will prevent you from having to schedule separate exams on separate days.
You can choose to do them on separate visits if you prefer. If you have a health concern, please inform your physician. They will let you know if it will be better to be addressed on the same day as the preventive visit.

If you have any questions concerning this, please ask to speak to the billing staff or the office manager.

I acknowledge receipt of and understanding of this policy.

______________________________	______________________
Patient Name	Patient Date of Birth
______________________________	______________________
Patient or Guardian Signature	Date