

Patient Registration Form

Please PRINT and COMPLETE ALL SECTIONS
Date: _____

PATIENT INFORMATION

Last Name First Name Middle Initial Nickname/AKA

Date of Birth Social Security Number Gender Male Female

Marital Status Married Single Divorced Separated Widowed Other Language other than English

Race: Black - Non Hispanic American Indian/ Alaskan Native Hispanic Asian/Pacific Islander White -Non Hispanic
(Optional) Other _____

Ethnic Group Argentinean Bolivian Central American Columbian Costa Rican Cuban Dominican Ecuadorian Guatemalan
 Hispanic or Latino Honduran Latin American Mexican Mexican American South American _____
 Other _____ Declined

Home Address Apt # City State Zip Code

Home Phone Work Phone Other Phone: Cell Pager Fax

Email Address Employment Status Active Duty Military Child Disabled Employed Full-Time Employed Part-Time
 Homemaker Not Employed Retired Self Employed Student Full-Time
 Student Part-Time Other _____

Employer Employer Phone

PATIENT'S INSURANCE INFORMATION RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Please present insurance cards to receptionist.

PRIMARY Insurance Name Address City State Zip Code

Name of Policy Holder Date of Birth Relationship to Insured Self Spouse Child Other

Relationship to Patient: Self (If self, skip to Emergency / Next of Kin) Spouse Parent Other

Last Name First Name Middle Initial

Date of Birth: Social Security Number:

Home Address Apt # City State Zip Code

Home Phone Work Phone Other Phone Cell Pager Fax

Employer Employment Status Active Duty Military Child Disabled Employed Full-Time Employed Part-Time
 Homemaker Not Employed Retired Student Full-Time Self Employed
 Student Part-Time Other _____

Employer Phone

SECONDARY Insurance Name Address City State Zip Code

Name of Policy Holder Date of Birth Relationship to Insured Self Spouse Child Other

Policy #: Group #: Co-Pay \$

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician Referring Physician

How did you hear about us?
 Employer Family Member Friend Health Fair Event Insurance Magazine Mail Physician Website Yellow Pages Other _____

Continued on next page

NEW PATIENT INFORMATION SHEET

Today's Date: _____
Patient Name: _____ **DOB:** _____
 Single Married Separated Divorced Widowed
 Years completed in: High School: _____ Years in College: _____ Degree(s): _____
Allergies
 Penicillin, Sulfa, antibiotics Codeine or Morphine Aspirin Insect Bites/Stings Foods
 Other: _____
 Are you current with all immunizations: **Tetanus** Yes No **Hep A** Yes No **Hep B** Yes No
Gardasil Yes No **Flu** Yes No **Pneumonia** Yes No

HISTORY OF PRESENT ILLNESS:

What is the reason for your visit today: _____
 Do you have any current or history of the following:
 Urinary Problems Yes No Please describe: _____
 Skin Yes No Please describe: _____
 Eyes Yes No Please describe: _____
 Ears/Nose/Throat Yes No Please describe: _____
 Cardiovascular Yes No Please describe: _____
 Respiratory Yes No Please describe: _____
 Gastrointestinal Yes No Please describe: _____
 Endocrine Yes No Please describe: _____
 Musculoskeletal Yes No Please describe: _____
 Neurological Yes No Please describe: _____
 Psychiatric Yes No Please describe: _____
 Hematologic/Lymphatic Yes No Please describe: _____
 Other Yes No Please describe: _____
 How long have you had this problem? _____
 Any other signs or symptoms? _____
 What were you doing when you noticed this problem: _____
 How many times have you been pregnant? _____ How many living children do you have? _____
 Did you have a C-section or vaginal birth? _____

FAMILY HISTORY: (Please check all that apply)

	Allergies	Asthma	Arthritis	Birth Defects	Cancer	Depression	Glaucoma	Heart Trouble	High Blood Pressure	Kidney Trouble	Mental Retardation	Sickle Cell Anemia	Stroke	Epilepsy/Seizures	Substance Abuse
Father															
Mother															
Brother/Sister															
Grandparent															
Spouse															
Children															

Is there any history of Tuberculosis or Suicide in your immediate family; if yes, please explain: _____

Please list the date of you last exam/test:
 Physical: _____ Physician Name: _____
 Pap Smear: _____ Physician Name: _____
 Mammogram: _____ Physician Name: _____
 Cholesterol: _____ Physician Name: _____
 EKG: _____ Physician Name: _____
 Stool Test (blood): _____ Physician Name: _____
 Sigmoidoscopy: _____ Physician Name: _____

(continued on next page)

HOSPITALIZATIONS: *List all hospital stays beginning with the most recent*

Date	Reason	Hospital Name	Physician

SURGICAL HISTORY(S) *List all surgery, beginning with the most recent*

Date	Type of Surgery	Surgeon Name

MEDICATION: *List all medication(s) you presently take. Please include over-the-counter and any other supplements that you take daily.*

SOCIAL HISTORY – Please answer all

ALCOHOLIC BEVERAGES

Never Less than 6/week 7-24 drinks/week over 24 drinks/week

TOBACCO

Cigarettes – Pack/day _____ Cigars - #/day _____ Pipe - #/day _____

Smokeless Tobacco: Snuff - #/day _____ Chewing Tobacco - #/day _____

Age started using tobacco: _____ Age stopped using Tobacco: _____

DIET

Please List any special Diet: _____

EXERCISE

Type / Frequency: _____



Appointment and Cancellation Policy for Medical Appointments and Procedures

Our goal is to provide quality medical care in a timely manner. In order to do so we have had to implement an appointment/cancellation policy. The policy enables us to better utilize available appointments for our patients in need of medical care.

Scheduled Appointments

For a scheduled appointment please call: 770-975-9077

We encourage that you schedule appointments for preventative health visits, physicals, pap exams, chronic medical conditions, prescription renewals.

Cancellation of an Appointment

In order to be respectful of the medical needs of the Concordia community please be courteous and call the Health Services promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. This is how we can best serve the needs of the Concordia Community.

If it is necessary to cancel your scheduled appointment we require that you call 24 hours before the scheduled appointment time, (1) working day in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

How to Cancel Your Appointment

To cancel appointments please call 770-975-9077. If you do not reach the receptionist you may leave a detailed message on the voice mail. You may not cancel via email.

Late Cancellations

A late cancellation is an appointment cancelled less than 24 hours of the scheduled appointment time, one (1) working day in advance or cancelled the same day as the appointment. Late cancellations will be considered as a “no show” and will be assessed a fee of \$25. This fee will be collected before another appointment will be scheduled.

No Show Policy

A “no show” is someone who misses an appointment without canceling it within 24 hour of the scheduled appointment. No-shows inconvenience those individuals who need access to medical care in a timely manner.

A failure to present at the time of a scheduled appointment will be recorded in the patients’ chart as a “no show”. An administrative fee of \$25.00 for the first “no show” will be billed to the patient’s account. The patient will be sent a letter alerting them to the fact that they have failed to show up for an appointment and did not cancel the appointment within 24 hours of the missed appointment, on (1) working day in advance. A Copy of the letter will be placed in the patient file. Three “no shows” will result in the suspension of services.

Policy Acknowledgement

I have read and been informed about the content, requirements, and expectations of the appointment and cancellation policy for patient at Governors Family Medical Group. I agree to abide by the policy guidelines as a condition while under care with Governors Family Medical Group. I understand that if I have questions, at any time, regarding the appointment and cancellation policy, I will consult with staff members of the clinic.

Please read the policy carefully to ensure that you understand the policy before signing this document.

Patient / Patient Guardian Signature: _____ Date: _____

Patient/ Patient Guardian Printed Name: _____ Date: _____



Heath Trowell, MD
Ashley Trowell, MD

4900 Ivey Road, Ste 1826, Acworth, GA 30101
Phone: (770) 975-9077 Fax: (770) 790-4964

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to
(Name/ Address/ Phone of Facility/Provider currently holding records)
release healthcare information, x-rays, and reports of the patient named above to:

Governors Family Medical Group
4900 Ivey Road, Ste 1826
Acworth, GA 30101
Phone: (770) 975-9077 Fax: (770) 790-4964

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: _____

All healthcare information

Other: _____

Patient Signature: _____ Date Signed: _____



Confidential Communication Request

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPPA), you have a right to request that communications concerning your personal health information be made through confidential channels. The Practice will not ask you why you are making your request and will make reasonable efforts to accommodate all reasonable requests. Some method of contact must be provided and, as appropriate, information as to how payment will be handled.

I, _____(print name), hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment. This request supersedes any prior request for confidential channel communications I may have made. Please select all that apply. Where you list more than one communication option, please indicate which you prefer.

Phone

I want you to contact me by telephone _____

Cell: _____

Do Do Not Leave message on my answering machine _____

Home: _____

Do Do Not Leave message with any other person _____

Work: _____

Mail

I want you to contact me at the following address: _____

Address 1 _____

Address2 _____

City/State/Zip _____

Email

I want you to contact me at the following e-mail address: _____

Fax:

I want you to contact me at the following fax #: _____

Patient/Guardian Signature

Date

Please Print Guardian Name

If not signed by the patient, Please indicate relationship:

- Parent or Guardian of minor patient.
- Guardian or conservator of an incompetent patient.
- Beneficiary or personal representative of deceased patient.



4900 Ivey Road NW, Ste 1826, Acworth, GA 30101
770-975-9077 / F- 770-790-4964

Financial Policy

Thank you for choosing **Governors Family Medical Group** as your family health care provider. We are committed to providing you the best possible medical care. We would like to keep you informed of our current office and financial policies. We require you to read and sign this agreement. We will place a signed copy in your chart, and you may keep the original for future reference.

Insurance: As a courtesy, our office will bill your insurance for the services you receive. We cannot bill your insurance company unless you give us your correct insurance information. Please understand that your medical insurance is a contract between you and your insurance company; **your bill is ultimately your responsibility whether your insurance company pays or not.** We can often help with providing information to help get your claim paid, but **if your insurance company has not paid your account in full within 45 business days, it will then become your responsibility to pay the balance.**

Co-payments, deductibles and fees: All co-payments, insurance deductibles and fees for services not covered by your insurance policy are due at the time service is rendered. **The co-pay cannot be waived, as it is a requirement placed on you by your insurance company.**

No insurance: Payment is due at the time of service.

Payment: We accept cash, personal checks, VISA, Master Card.

Returned checks: A **\$30.00** charge will be added to your account for any check returned by your bank for any reason. This will be in addition to any charges applied by your bank.

Missed appointments: If you are unable to keep your scheduled appointment, please call our office at least 24 hours in advance to cancel or to reschedule. This will allow us to provide that time slot to another patient. If they are not cancelled at least 24 hours in advance, it is our policy to charge **\$25.00** for missed office appointments. The missed appointment fee cannot be billed to insurance, and is the responsibility of the patient.

New patients who miss an appointment may reschedule, however will not be eligible for scheduling after three missed appointments. Established patients who miss an appointment may reschedule, but missing three appointments in a 12 month period will result in dismissal from our practice.

* * * * *
I have read the Governors Family Medical Group Financial Policy in full, and I understand and agree to this policy. I acknowledge full financial responsibility for services rendered by Drs. Shannon Heath Trowell and/or Cheryl Ashley Trowell. I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance, including deductibles and co-payments. I understand that payment of co-payments is expected at the time of service, as well as any prior balance that I owe. I understand the policy regarding missed appointments. I also consent that the payment of authorized Medicare insurance benefits be made on my behalf directly to Governors Family Medical Group for any medical services furnished.

Printed Name Signature of Patient Date Signed



NOTICE OF PRIVACY PRACTICES

Effective September 2009

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.

The Health Insurance Portability and Accountability Act of 1966 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

A. How Governors Family Medical Group May Use or Disclose Your Health Information

We may use and disclose your medical records only for each of the following purposes:

- **TREATMENT** – providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include performing diagnostic tests in our office.
- **PAYMENT** – such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **HEALTH CARE OPERATIONS** – include the business aspects of running the practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

There are times we may be required by law to disclose information for law enforcement or public health reasons without an additional authorization from the patient.

B. When Governors Family Medical Group May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, Governors Family Medical Group will not use or disclose health information which identifies you without your written authorization. If you do authorize the practice to use or disclose health information for another purpose, you may revoke your authorization in writing at any time. We are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

(continued next page)

C. Your Health Information Rights

You have the following rights with respect to your protected health information (PHI), which you can exercise by presenting a written request to the Privacy Officer using Practice forms:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures to family members, other relatives, close personal friends or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of PHI, including those related to disclosures to family members, other relative, close personal friends or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of PHI from us by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend you PHI.
- The right to obtain a paper copy of this Notice from us upon request.

We are required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI.

D. Changes to this Notice of Privacy Practices.

We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PHI that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from the practice.

E. Complaints

If you believe there has been a problem with our collection, use or disclosure of your PHI, you have the right to file a complaint with our Privacy Officer. If we do not respond to your complaint in a satisfactory manner, you may file a complaint with the U.S. Office of Civil Rights. We will not retaliate against you for filing a complaint.

For More information about HIPAA or to file a complaint contact:

The U.S. Department of Health & Human Services
Office of Civil Rights
61 Forsyth Street, SW, Ste 3B70
Atlanta, GA 30303-8909
Telephone (404) 562-7886 or (404) 331-2867 (TDD)
FAX: (404) 562-7881

www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaintpackage.pdf