# Clarke-Oconee Family Practice

## Patient Registration Form

**Patient Information** (Please Print)

☐Dr. ☐Mr. ☐Mrs. ☐Ms. ☐ Jr. ☐Sr. ☐Other_______________
Patient's Name (Last)_____________________ (First) ____________________ (Middle) _____________________
Also Known As Name (Last)_______________________________ (First) _______________________________
Marital Status ☐Married ☐Single ☐Divorced ☐Widowed ☐Legally ☐ Separated ☐Other
Social Security Number____________________ Sex ☐Male ☐Female
Race___________________________________ Ethnicity___________________________________
Email Address__________________________________________________________________________________
Phone Number Home_________________________ Cell_________________________
Work_________________________
Address________________________________________________________________________________________
City, State, Zip Code______________________________________________
Employment Status:
☐Employed ☐Full-Time Student ☐Part-Time Student ☐Retired ☐Self-Employed ☐Unemployed
Employer____________________________________ Occupation____________________________________
Emergency Contact____________________________________ Relationship_________________________
Emergency Contact Phone Number________________________________

**Responsible Party Information (If other than self)**

Responsible Party's Name (Last)__________________ (First) _________________ (Middle) _________________
Social Security Number____________________ Sex ☐Male ☐Female
Email Address__________________________________________________________________________________
Phone Number Home_________________________ Cell_________________________
Work_________________________
Address________________________________________________________________________________________
City, State, Zip Code______________________________________________
Patient Relationship to Responsible Party__________________________________________________________

**Primary Insurance Information**

Name of Insured_____________________________ Relationship to Insured____________________________
Insurance Company________________________________________________________________________
Subscriber ID / Policy Number_____________________________ Group ID_____________________________
Effective Date________________________ Insured Date of Birth__________________________

**Secondary Insurance Information**

Name of Insured_____________________________ Relationship to Insured____________________________
Insurance Company________________________________________________________________________
Subscriber ID / Policy Number_____________________________ Group ID_____________________________
Effective Date________________________ Insured Date of Birth__________________________

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature____________________________________________ Date_____________

# Clarke-Oconee Family Practice

**Name** ______________________________ **Date of Birth** ____________________

Why are you here?_____________________________________________

History of illness – ***Please answer all of the following questions:***

- Where is your problem? ______________________________________________
- Where were you when you noticed this problem?_____________________________
- How long have you had this problem?_____________________________________
- How severe is your problem?___________________________________________
- What makes it better or worse?_________________________________________

| ALLERGIES |
|---|
| |
| |
| |
| |
| **CURRENT MEDICATIONS** |
| |
| |
| |
| |
| |
| |
| |

**FAMILY HISTORY**

| | Father | Mother | Paternal Grandfather | Paternal Grandmother | Maternal Grandmother | Maternal Grandfather | Children | Siblings |
|---|---|---|---|---|---|---|---|---|
| Heart Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cancer | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Glaucoma | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Epilepsy / Convulsions | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Bleeding Disorder | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Kidney Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Thyroid Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Mental Illness | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## Procedure / Hospitalization / Surgery

| Date | Reason | Date | Reason |
|---|---|---|---|
| | Colonoscopy | | |
| | Endoscopy | | |
| | Cardiac / Heart | | |
| | | | |

## Immunizations Records

| Immunization | Date Received | Immunization | Date Received |
|---|---|---|---|
| Influenza | | Hepatitis-B | |
| Tetanus | | Shingles | |
| Pneumovax-23 | | Prevnar-13 | |
| Typhoid | | | |

**Social History** (check those that apply)

- ☐ **Snuff: Amount Daily**______________________
- ☐ **Exercise Routine**________________________
- ☐ **Diet Restrictions**______________________
- ☐ **Past Drug Use**__________________________
- ☐ **Smoke: Age Started / Amount Daily**________________________
- ☐ **Alcohol: Type / Amount**_____________________________
- ☐ **Contact with blood or bodily fluid at work?**__________________
- ☐ **Number of Sexual Partners: _____MALE / _____FEMALE**

Patient (or Responsible Party) Signature_______________________________________ Date____________


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*Board Certified American Board of Family Physicians*

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*revised 03/28/2017*

# Clarke-Oconee Family Practice

## REVIEW OF SYSTEMS:

**PLEASE CIRCLE Y (YES) OR N (NO) IF YOU HAVE OR ARE EXPERIENCING THE ISSUES BELOW:**

**PATIENT NAME**________________________________ **DATE**________________

**GENERAL:** Fever Y N. Chills Y N. Night sweats Y N. Unexpected / unexplained weight change Y N. Cancer Y N. Chronic Fatigue Y N.

**ENDOCRINE:** Hyperlipidemia (High Cholesterol) Y N. Diabetes Y N. Thyroid disease Y N.

**HEMATOLOGIC/LYMPHATIC:** Anemia Y N. Bruise easily Y N. Bleeding diseases (Free Bleeder) Y N. Are You Taking Blood thinners Y N. Sickle Cell Anemia Y N.

**HEENT:** Decreased Hearing Y N. Ringing in ears Y N. Frequent ear infections Y N. Nose bleeds Y N. Sinus trouble Y N. Sore throats Y N. Hay fever Y N. Allergies Y N.

**EYES:** Failing vision Y N. Double/blurred vision Y N. Eye pain Y N. Eye infections Y N.

**RESPIRATORY:** Pneumonia Y N. Bronchitis Y N. Chronic cough Y N. Asthma Y N. Wheezing Y N. Shortness of Breath on Exertion Y N. and / or when lying flat Y N. Cystic Fibrosis Y N. Hoarseness Y N.

**CARDIOVASCULAR:** Hypertension (High Blood Pressure) Y N. Chest pain on exertion Y N. and / or at rest Y N. Heart murmur Y N. Palpitations Y N. Irregular Pulse Y N. Swollen ankles Y N. Fainting spells Y N. Leg pain with walking Y N. Varicose veins Y N. Phlebitis (Inflammation of the veins) Y N. Cold numb feet Y N. Peripheral Vascular Disease Y N. Heart Disease Y N.

**GASTROINTESTINAL:** Recent loss in appetite Y N. Difficulty swallowing Y N. Heartburn Y N. Peptic ulcers Y N. Abdominal pain Y N. Nausea Y N. Vomiting Y N. Diarrhea Y N. Constipation Y N. Diverticulosis Y N. Bloody or tarry stools Y N. Hemorrhoids Y N. Gallbladder trouble Y N. Hepatitis Y N.

**GU/GENT:** Hernia Y N. Frequent urinary infections Y N. Painful urination Y N. Blood in urine Y N. Overnight urination-more than 2 times Y N. Loss of Control of urination Y N. Difficulty in initiating urination Y N. Kidney stones Y N. Venereal disease Y N. Prostate Disease Y N. Sexual Dysfunction Y N. Urethral discharge Y N.

**GYN/FEMALE:** Gravida (Number of Pregnancies) ___. Para (Number of live births) ___. Abortion (Number) ___. Miscarriages (Number) ___. Menarche (Age of starting menstrual cycles) _____. Irregular menstruation Y N. Hot Flashes Y N. Menopause Y N.

**MUSCULOSKELETAL:** Recurrent back pain Y N. Bone fractures Y N. Joint injury Y N. Gout Y N. Foot pain Y N. Arthritis/Rheumatism Y N. Muscle weakness Y N. Muscle pain Y N.

**INTEGRA/SKIN:** Rashes Y N. Hives Y N. Psoriasis Y N. Eczema Y N. Acne Y N. Rosacea Y N.

**NEURO:** Headaches Y N. Migraines Y N. Dizzy spells Y N. Seizures Y N. Stroke Y N. Tremor/Hands shaking Y N. Numbness/Tingling sensations Y N.

**PSYCH:** Difficulty sleeping Y N. Nervousness Y N. Depression Y N. Memory loss Y N. Excessive moodiness Y N.

**CHILDHOOD ILLNESSES/ADULT ILLNESSES:** Chicken Pox Y N. Measles Y N. Polio Y N. German Measles Y N. Rheumatic Heart Disease Y N. Scarlet Fever Y N. Mumps Y N. Tuberculosis Y N.

Patient (or Responsible Party) Signature_______________________________________ Date_____________



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# Clarke-Oconee Family Practice

## Depression PHQ

Name________________________________ Date:___________________

| Over the last 2 weeks how often have you been bothered by any of the following problems? | Not at All | Several Days | More than Half the Days | Nearly Everyday |
|---|---|---|---|---|
| Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| Feeling down, depressed or hopeless | 0 | 1 | 2 | 3 |
| Trouble falling sleep, or sleeping too much | 0 | 1 | 2 | 3 |
| Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| Poor appetite or overeating | 0 | 1 | 2 | 3 |
| Feeling bad about yourself—that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| Trouble concentrating on things such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| Moving or speaking so slowly that other people have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| Thoughts that you would be better off dead or hurting yourself in some way | 0 | 1 | 2 | 3 |
| (Office use ONLY) | ____ | ____ | ____ | ____ |

If you have experienced any of these problems, how difficult have they made if for you to do your work, take care of things at home, or get along with other people?

☐Not Difficult at All ☐Somewhat Difficult ☐Very Difficult ☐Extremely Difficult

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*revised 03/28/2017*

# Clarke-Oconee Family Practice

## Mood Questionnaire

Name________________________________ Date:___________________

Has there ever been a period of time when you were not your usual self and …

| | YES | NO |
|---|---|---|
| You felt so good or so hyper that other people thought you were not your normal self, or you were so hyper that you got into trouble? | | |
| You were so irritable that you shouted at people or started fights or arguments? | | |
| You felt much more self-confident than usual? | | |
| You got much less sleep than usual and found you didn't really miss it? | | |
| You were much more talkative and / or spoke much faster than usual? | | |
| Thoughts raced through your head and / or you couldn't slow your mind down? | | |
| You were so easily distracted by things around you that you have trouble concentrating or staying on track? | | |
| You had much more energy than usual? | | |
| You were much more active and / or did many more things than usual? | | |
| You were much more social or outgoing than usual—for example, you called friends in the middle of the night? | | |
| You were much more interested in sex than usual? | | |
| You did things that were unusual for you or that other people might have thought were excessive, foolish or risky? | | |
| Spending money got you or your family in trouble | | |
| If you checked YES to more than one of the above, have you experienced several of these during the same period of time? | | |

How much of a problem did any of these situations cause you (like being unable to work; having family, money or legal problems; and / or getting into serious arguments or fights)?

☐Not a Problem ☐Minor Problem ☐Moderate Problem ☐Serious Problem

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# Clarke-Oconee Family Practice

## Appointment Office Policies

**For New Patients**

Please arrive at least 30 minutes before your appointment, allowing ample time for traffic and parking. You will need this time to complete and sign any forms, and time for our staff to make the necessary copies of your insurance information.

Please make sure you have your current insurance care and photo ID when you arrive for your appointment.

**For Established Patients**

Each time you visit the office, please make sure that we have the **most current** insurance information and demographic information (address, phone numbers, etc.)

Please arrive 15 minutes before you appointment allowing ample time for traffic and parking. If you are more than 15 minutes late for your appointment, you will have to be rescheduled.

Prescriptions will no longer be called into the pharmacy. If you need a refill, you need to contact the pharmacy and have them send us an electronic refill request. We will respond within the next 24 hours after receiving the request. The physician will not refill any prescriptions if you did not keep your last appointment or if it has been more than six (6) months since your last appointment. If you need a new prescription, you will need to schedule an appointment to be seen by the physician.

---

Patient Name: Date:

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Signature:

---

Witness Signature: Date:

# Clarke-Oconee Family Practice

**Patient Office Orientation**

Office Hours:
Monday-Thursday: 8:00am-5:00pm (Phones will be answered after 8:30am)
Friday: 8:00am-12:00pm (Phones are answered after 8:30am)
*There are circumstances where there will be appointments scheduled on Friday afternoons*
Lunch: 12:00pm-1:30pm (The phones will be turned over to voicemail during this time; please either leave a voicemail, or call back after 1:30pm)

Contact Information:
Main Phone Number: (706) 353-7747
After Hours Phone Number: (706) 353-7157
Fax: (706) 353-7756
Email: recep@clarkeoconeefp.com / nursing@clarkeoconeefp.com / COFP@clarkeoconeefp.com
Website: www.clarkeoconeefamilypractice.com

- Registration Forms
- Contact Link
- Office / Staff Information

Medical Care After Hours:

- Piedmont Athens Regional Emergency Room
- St. Mary's Healthcare System / Emergency Room
- Piedmont First Care
  - (Athens) Hwy 29 North / phone: (706) 353-6000
  - (Watkinsville)1960 Experiment Station Road / phone: (706) 769-0000
  - (Jefferson) 528 Panther Drive / phone: (706) 387-5555
  - (Bethlehem) 340 Exchange Boulevard / (678) 963-7171
- SmartCare Urgent Care
  - 1480 Baxter Street, Athens, GA 30606
- Reddy Medical
  - 1061 Dowdy Rd. #100, Athens, GA 30606
- Reddy Urgent Care
  - 283 E. Broad Street, Athens, GA 30601

Patient Portal:
MYHEALTHWARE.COM: Patients are instructed not to use the Patient Portal for emergency clinical advice. Please make sure your email address is given to the staff. An invitation will be sent to you through your email.

# Clarke-Oconee Family Practice

What is a Patient-Centered Medical Home?

Patient-Centered Medical Home coordinates your medical care as a healthcare team—putting the focus of your health on you, where it belongs! It is a partnership between the healthcare team and the patient. The Patient-Centered Medical Home team facilitates a partnership between individual patients, his or her primary care physician, and the patient's family. Medical care is facilitated by evidence based guidelines through registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need. Patients are assured that medical care will be carried out in a culturally and linguistically appropriate manner.

What are the changed and additionally benefits that one can expect?

**Team Based Care:**
Your Primary Care Physician is the team leader. The team will be supported by the medical office staff and support staff to work with you to meet all of your medical needs. We will use information systems tools and medical registries to optimize your medical care.

**Improved Health Access and Communications:**
For urgent care issues during working hours, your Primary Care Physician will see you on the very day that you have an urgent health care need. You will need to simply call the main office number (706-353-7747) during working hours to schedule a same-day appointment. Many urgent care needs, including lacerations, can be handled here in the office. You will then avoid having a prolonged and expensive visit to the local emergency room.

**Patient-Centered Medical Home Pledge:**

- We listen to your questions and concerns and will clearly explain disease / diagnosis, treatment and results of diagnostic tests.
- The Care Team is responsible for coordinating your care whether with specialists or resources in the community.
- We will provide clear instructions about your treatment goals and future plans for every visit. You will receive a Care Plan / Plan of Care with every visit.
- We will continue to learn and improve in the quality of care through evidence-based performance measures: on clinical care, patient's experience and practice operations and on its impact on healthcare costs.
- As a medical home the practice will provide behavioral health needs through annual depression screening, medical management and referrals for counseling and psychiatric evaluation and needs.

**What We Ask of You:**

- Ask questions and actively participate in your care.
- Provide you complete medical history and other important information including any changes in your health and information about care outside the practice.
- Sign a Transfer of Medical Records form to have your medical records released and return it to the front office staff.

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- Review your “care plan” after every visit for there will be vital information regarding your visit, care and goals of treatment.

**We Accept the following Insurances:**

- BlueCross BlueShield
- Aetna
- Humana
- Tricare
- Cigna
- Cigna HealthSpring
- Coventry
- Medicare
- United Healthcare
- We often accept third party insurance companies, please call the office to check if we are a participating partner.

**Payment options:**

- Cash
- Credit Cards: Visa, MasterCard, Discover
- Checks
- Health Savings Accounts or Health Flex Accounts

We provide equal access to all patients regardless of their source of payment. Payment is expected at the time of service.

If you have any questions, please do not hesitate to ask our office staff.

# Clarke-Oconee Family Practice

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ CAREFULLY.**

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on August 1, 2016 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting out Privacy Office, Tori Shelton. Information on contacting us can be found at the end of this Notice.

**TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION**

We will keep your health information confidential, using it only for the following purposes:

**Treatment:** We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

**Disclosure:** We may disclosure and/or share your healthcare information with other health care professionals who provide treatment and/or service to you either by fax or electronically through electronic medical records. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. The uses and disclosures not describes in the notice will be made only with authorization from the individual.

**Payment:** We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves out business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

**Emergencies:** We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

**Healthcare Operations:** We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

**Required by Law:** We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

**Public Health Responsibilities:** We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease / infection exposure and to prevent and control disease, injury and/or disability.

**Marketing Health-Related Services:** We will not use your health information to marketing purposed unless we have your written authorization to do so.

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**National Security:** The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

**Appointment Reminders:** We may use or disclosure your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

**YOUR PRIVACY RIGHTS AS OUR PATIENT**

**Access:** Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be charged according to the Georgia State Copy Law. If you want the copies mailed to you, postage with also be charged. If you prefer a summary or an explanation of your health information, we will provide it all for free. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

**Amendment:** You have the right to amend your healthcare information, if you feel it is accurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

**Non-routine Disclosure:** You have the right to receive a list of non-routine disclosures we have made of your health care information. You have the right to a list of instances in which we, or our business associates, disclosed information for reasons other than treatment, payment or healthcare operations. You can request non-routine disclosures going back to 6 years prior to the date of your request.

**Restrictions:** You have the right to request that we place additional restrictions on our use or disclosure of you health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer f you want to further restrict access to your health care information. This request must be submitted in writing.

**Breach:** An individual has the right to notice in the event of a breach. If a breach does occur, our Privacy Officer will contact you directly to inform you.

**QUESTIONS AND COMPLAINTS**

You have the right to file a complaint with us if you feel we have not compiled with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to a file a complaint with us or with the U.S. Department of Health and Human Services. The toll free number for the U.S. Department of Health and Human Services is 1-888-696-6775.

**HOW TO CONTACT US**

Practice Name: Clarke-Oconee Family Practice
Privacy Officer: Tori Shelton
Telephone: (706) 353-7747
Fax: (706) 353-7756
Email: recep@clarkeoconeefp.com
Address: 1010 Prince Avenue, Suite 182 Athens, GA 30606

# Clarke-Oconee Family Practice

**Privacy Consent**

Patient Name____________________________ Date of Birth_______________

Please refer to the Notice of Privacy Practices (NPP) on the previous two pages of this packet. This notice states that we may disclose your protected health information (PHI) to others who are involved in your care, such as spouse, children, parents, caregivers or others.

Please complete either section A or B:
A
If you do not wish for us to disclose your PHI to anyone, please initial here______

B
List anyone you would authorize us to share or discuss your PHI. This could include medical treatment, diagnosis, or releasing of records.

Name_________________________________Relationship__________________

Name_________________________________Relationship__________________

Name_________________________________Relationship__________________

Name_________________________________Relationship__________________

Name_________________________________Relationship__________________

You may change or revoke this consent at any time by completing a new form or sending our office a letter.

---

Patient Name: Date:

---

Signature:

---

Witness Signature: Date:

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# Clarke-Oconee Family Practice

**Payment Policy**

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions in the past regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign it in the space provided. A copy will be provided to you upon request.

- **Insurance:** We participate in most insurance plans. If you are not insured by a plan we do business with, payment in full will be expected at each visit. If you are insured by a plan we do business with but don't provide our office with an updated card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
- **Co-payments and deductibles:** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud.
- **Non-covered services:** Please be aware that some—and perhaps all—of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. If this is the case, we will explain all non-covered services and their cost before any testing is performed. You will be asked to sign a form stating your understanding.
- **Proof of insurance:** All patients my complete our patient information from before seeing the doctor. We will need a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.
- **Claims submission:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. If is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
- **Coverage changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
- **Non-payment:** If your account is over 90 days past due, it will be placed with a collection agency. Once placed in collections, all fees incurred in collecting the debt, including any legal fees, will be added to the patients balance, and become the responsibility of the patient of guarantor. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, you and your immediate family members may be discharged from this practice. If this were to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis. **Please initial here___________.**
- **Missed appointments:** Our policy is to charge $25.00 for each missed appointment not cancelled within 24 hours. This charge will be your responsibility and billed directly to you. After three (3) no-show appointments, you will be dismissed from the practice. Please help us to serve you better by keeping your scheduled appointments. **Please initial here________.**

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

---

Patient Name: Date:

---

Signature:

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Witness Signature: Date:

Jonathan Mitchell Cook, D.O. FAAFP *revised 03/28/2017*

*Board Certified American Board of Family Physicians*

1010 Prince Avenue Suite 182 Athens, Georgia 30606 Phone: (706) 353-7747 Fax: (706) 353-7756

# Clarke-Oconee Family Practice

**Insurance Policy**

Dear Valued Patient,

Insurance companies have many types of plans. These plans often have a copay, coinsurance, and deductible associated with them. Many plans require advance notification and authorization prior to rendering no-emergency health care services.

Please be advised that if you have insurance, it is you responsibility to know your health plan's policy and all the requirements. If prior approval, pre-certification, or authorization is needed, we will be more than happy to assist you.

Lastly, if your insurance company allows claim appeals, by signing this form, you give us the right to submit claim appeals on your behalf. In the event that the appeal denies, *the balance is your responsibility.* All balances for services are due at the next time of service. We will also work with you to make payment arrangements, if this is necessary.

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Patient Name: Date:

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Signature:

---

Witness Signature: Date:



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# Clarke-Oconee Family Practice

**AUTHORIZATIAON FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)**

Patient Information:

Name (Last)______________________ (First) _____________________ (Middle) _____________________

Date of Birth_______________ Social Security Number (last 4 digits) ___________

Street Address______________________________________________________________________________

City, State, Zip Code ______________________ Phone Number____________________________

*I authorize Clarke-Oconee Family Practice to: (check one below)*

☐ Release Information to: ☐ Obtain Information from:

Physician or other entity__________________________________________________________________

Street Address______________________________________________________________________________

City, State, Zip Code _____________________________________

Phone Number___________________________ Fax Number___________________________

For the Purpose of:

☐ Transfer of Medical Care (permanent release) ☐ Personal ☐ Disability ☐ Pre-surgical Evaluation
☐ Insurance ☐ Legal ☐ Other____________________________________________

**Unless indicated by specific request checked below, I permit the release of any and all information including, if any, information concerning drug / alcohol abuse records, venereal disease and other statutorily protected diseases, psychiatric records (excluding psychotherapy notes), or HIV / AIDS testing treatment records.**

Please check the specific information requested for release:

☐All PHI in medical record ☐ER report(s) ☐History and Physical ☐Pathology report(s) ☐Discharge summary ☐Operative report(s) ☐Progress / office notes ☐Laboratory report(s) ☐Radiology report(s) ☐Other_____________________________________________________

I understand that:

- I may revoke this authorization at any time in writing and present my written revocation to Clarke-Oconee Family Practice. The revocation will not apply to information that has already been released immediately after the authorization and before the official revocation.
- This is a completely *voluntary* process.
- Any disclosure of information carries with it the potential for an unauthorized re-disclosure.
- I can request a copy of this form after I sign it.

Unless otherwise revoked, this authorization will expire on the following date, event or condition: _______________________________________________________________. **If I fail to specify an expiration date, even or condition, this authorization will expire in ninety (90) days.**

*I have read the above and authorize the disclosure of my protected health information as indicated.*

Signature of Patient or Legal Representative________________________________________

Date_________________ Time_________________

If signed by someone other than self, please state the relationship:________________________

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