VININGS MEDICAL CENTER
2255 Cumberland Pkwy, Bldg 1400 - Atlanta, GA 30339

Patient Registration

Patient Information

Patient name (Last, First)

Patient date of birth *Patient gender (M / F)* *Patient marital status*

Mailing address (address number & street)

Patient Social Security Number *Employment / student status*

Mailing address (apartment no., etc.)

Employer or school name

City, State, ZIP Code

Work telephone (include extension)

Home telephone *Cell phone*

When we need to leave a message which number may we use?

May we activate your Web-based patient portal? ☐ *Yes* ☐ *No*

E-Mail address (used for patient portal notifications)

Guarantor Information (skip if same as patient)

(The guarantor is the individual holding your insurance policy or responsible for payment)

Guarantor name (Last, First)

Guarantor date of birth *Guarantor gender (M / F)*

Mailing address (address number & street)

Guarantor Social Security Number

Mailing address (apartment no., etc.)

Relationship to patient

City, State, ZIP Code

Work telephone (include extension)

Home telephone *Cell phone*

Employer name

E-Mail address

May we leave a message at work?

Emergency Contact Information

Name (Last, First)

Primary phone number *Secondary phone number*

Do you have a living will? *Would you like information on one?*

Insurance Information

Primary insurance company name

Secondary insurance company name (if applicable)

Relationship of patient to insured:

☐ *Self* ☐ *Spouse* ☐ *Dependent Child* ☐ *Other:*_____

Relationship of patient to insured:

☐ *Self* ☐ *Spouse* ☐ *Dependent Child* ☐ *Other:*_____

Pharmacy Information

Pharmacy name and address

Pharmacy Telephone

Next page, please

Terms & Policies

1. ESTABLISHING An individual seeking treatment is not a patient until after they have been evaluated by a practice physician for a scheduled, face-to-face, appointment. Simply scheduling an appointment or faxing in new patient registration forms does not establish any such relationship.
2. NO-SHOW, CANCELLATION, AND LATE ARRIVAL POLICY (necessary to preserve access for our established patients).
   a. I understand the practice requires a twenty-four (24) hour notice of cancellation for any appointment.
   b. Should I decide not to provide such notice I agree to pay $75.00 ($150.00 for physicals) in consideration for my lack thereof. If scheduled less than twenty-four hours before the appointment I agree to pay $75.00 in the event I cancel or no-show.
   c. Notice to new patients: New patients who no-show, show up late, or call the day of their new patient appointment to cancel or reschedule (regardless if calling before or after your scheduled appointment time) will not be allowed to establish with the practice, irrespective of the reason the appointment was missed.
   d. I understand my insurer, HSA, and HRA will not pay fees associated with no-shows and late cancellations.
   e. I understand two or more no-shows, late cancellations, or repeated late arrivals will result in dismissal from the practice.
3. ADMINISTRATIVE SERVICES Forms requiring completion outside a billable face-to-face visit with a physician will incur a $25.00 per page administrative processing charge which is due before we will process your form(s). This administrative processing fee covers specific administrative services which your insurer does not cover. Examples include but are not limited to: Family Medical Leave Act (FMLA), disability, life insurance, marriage licenses, foreign travel, adoptions, health clubs, letters for employers (other than basic work excuse letters), camps and schools (not including sport and camp physical forms related physicals performed in our office), and any miscellaneous letters or forms requested by you or a third party.
4. MAINTENANCE OF CONTACT INFORMATION I understand the practice will use the last address of record to communicate with me (e.g., invoices, lab results, reminder letters, etc.) via first class U.S. Mail and the last phone number of record for calls.
5. WEIGHT CONTROL MEDICATIONS We do not prescribe medications for weight loss.
6. CLAIMS FILING AGREEMENT AND ASSIGNMENT OF BENEFITS I authorize the practice to file insurance claims on behalf of the patient and I assign associated benefits to the practice.
7. MEDICARE, MEDICAID, EXCHANGE-BASED PLANS The practice does not accept Medicare or Medicaid - bear this in mind if you are considering enrolling in these plans in the future. We anticipate participating in the Piedmont-Wellstar Health Plan (an Exchange-based product); however, as of this time the product is still in development.
8. SELF-PAY PATIENTS Due to pricing complexities we are not accepting new self-pay patients at this time; however, if an existing patient loses their insurance we will work out a self-pay arrangement with such patients.
9. PCP ELECTION If my insurer requires a PCP election, I have selected Dr. Smith as my (or my dependent's) PCP and my insurer states the effective date of this change is on or before the date of the patient's first visit.
10. CREDITS. We automatically mail refunds on a quarterly basis when a credit of $25.00 or more exists on your account. Credits of less than $25.00 will remain on your account (for future co-pays, balances, etc.) unless you request a refund check.
11. FINANCIAL AGREEMENT. I understand and agree:
    a. I am ultimately responsible for payment of services provided;
    b. To pay balances on the patient's account which are not paid by insurance (e.g., co-payments, deductibles, co-insurance, PCP changes taking effect after patient's office visit, and charges which my insurer fails to pay or refuses to cover);
    c. To pay my balance within thirty days of initial invoicing. I also understand balances left unpaid after that time will incur a $5.00 rebilling fee per additional billing notice and will accrue interest from the original date(s) of service at the rate of 1.5% per month until paid in full;
    d. To be responsible for all costs, over and above the original balance, incurred by the practice in the collection of overdue balances on the patient's account including collection agency fees, attorney fees, and court costs, if applicable.
    e. I will incur a $35.00 service charge for any returned check.
12. PRIVACY PRACTICES The practice's Notice of Privacy Practices was made available to me which I may review at any time.
13. REQUESTS FOR COPIES OF MY MEDICAL RECORD Generally speaking, when you need us to forward all or certain parts of your medical record we will require you submit a written medical records request before we will process your request.
14. AUTHORIZATION TO TREAT I give Vinings Medical Center, P.C., its physicians, agents, employees, and contractors authorization to treat the patient listed herein.

I have read, understand and agree to these terms.

_____

Signature of Patient or Patient's Representative

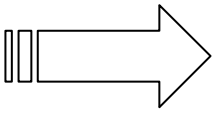
_____

Patient or Patient's Representative Name (please print)

_____

Today's Date

Next page, please



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Notification Regarding Billing for Preventive Exams

Some plans cover certain preventive services without cost to the patient. Typically, a patient will say, "My plan covers one 'free' visit per year" when their plan offers this benefit. While this may or may not be true, it is important to understand the difference between: a) a preventive exam; b) a problem-based exam; and c) what happens when the two are mixed during a wellness visit, i.e., a patient schedules a wellness exam but, upon meeting with the physician, also discusses a problem, illness, or symptom, "while I'm here," or if the physician discovers a problem, illness, or symptom in the course of performing the wellness exam.

So insurers and providers "talk the same language" when submitting claims, the health care industry uses a coding system designed by the American Medical Association to report services you receive to your insurer. Federal and state laws and our contracts with your insurer require we adhere to this system.

As defined under this system a preventive exam is performed in the absence of or separately from any problem, illness, or symptom previously known or that during the course of the exam becomes known. An example would be a patient that undergoes a wellness exam, does not mention or discuss problems, illnesses, or symptoms during the exam, and the physician does not identify problems, illnesses, or symptoms during the exam requiring additional evaluation or treatment.

Conversely, if: a) a patient schedules a wellness exam but also elects to discuss a problem, illness, or symptom during their visit; or b) a problem, illness, or symptom is discovered during the exam which requires additional evaluation or treatment; we are required to disclose and bill your insurer for additional problem-based services as they pertain to your problem-based issue. This is a separate, problem-based service in addition to your preventive exam service. In these circumstances we are not double billing your insurer – we are reporting and billing, as we are required to do (we don't have any say in the matter), that a preventive service and problem-based service were provided during your one visit to the office.

If you have a plan with a deductible, copay, or coinsurance for problem-based services your insurer may cover the preventive service component of your visit in full; however, they may apply the portion of your visit pertaining to your problem, illness, or symptom to your deductible which we are then required to bill you for. We are providing this notification to you before you meet with your physician today so you are aware of this in advance and will not be surprised if you are billed should you decide to discuss a problem with or if a problem is discovered by your physician during your wellness exam.

Why can't we just include the problem-based service with the preventive service and bill it to your insurer with one code? There is no single code under the American Medical Association billing system which combines a preventive and problem-based visit into one billing code. Your insurer audits your claims - intentionally misrepresenting the services that were provided to you when billing them to your insurer is a violation of our contracts with them and violates federal and state law.

If you have questions about this policy please discuss them with your insurer's member services representatives.

I have read, understand, and agree to these terms.

Signature of Patient or Patient's Responsible Party _____ Today's date _____

References:
(1) Aetna Benefits Guidance Statement Number 0016; Aetna Reimbursement Policy 99201-99205, 99211-99215; Aetna Office Links February 2009
(2) Cigna Reimbursement Policy Number R02 and M25
(3) United Healthcare Coverage Determination Guideline CDG-A-036; Preventive Medicine and Screening Policy Number 2011R0013B
(4) American Medical Association Current Procedural Terminology (CPT) © 2012
(5) Health Care Procedure Coding System, National Level II Medicare Codes ©

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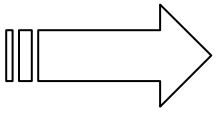

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Consent to Use and Disclosure of Protected Health Information

We are providing you this notice in accordance with applicable law. If you have any questions, please feel free to let us know.

1. Use and Disclosure of Your Protected Health Information:
   Your protected health information will be used by Vinings Medical Center, P.C. and may be disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

2. Notice of Privacy Practices:
   A copy of our current Notice of Privacy Practices is provided for your reference in the waiting room and on our Web site. Please refer to that document a complete description of how your protected health information may be used or disclosed.

3. Requesting Restrictions on the Use or Disclosure of Your Information:
   You may submit a written request to place a restriction on the disclosure of your protected health information. We will respond to you in writing if we are agreeable to your request.

4. Revocation of Consent:
   You may revoke this consent; however any such request must be submitted in writing. Any use or disclosure occurring prior to the date your revocation of consent is received by the practice are excluded, as are releases to parties you specifically authorize us to release your information to.

5. Reservation of Right to Change Privacy Practices:
   We may modify our Notice of Privacy Practices from time to time (typically as required to comply with evolving rules, laws, and regulations). A copy of our privacy practices which are in effect at any point in time is available in the waiting room and on our Web site.

In signing below, I give permission to Vinings Medical Center, P.C. to use and disclose my health information in accordance with the terms stated herein.

_____
Signature of Patient or Patient Representative

_____
Name of Patient (please print)

_____
Today's Date

On to history form, please

VININGS MEDICAL CENTER
2255 Cumberland Pkwy, Bldg 1400 - Atlanta, GA 30339

Medical History

Your thorough completion of this form is very important as it assists us in understanding your current and historical medical status. If you have any questions when completing this form please let us know.

Patient Information

_____ _____ _____
Patient name (Last, First) *Patient date of birth* *Today's Date*

Current Prescription Medications

Name of medication	*Dose (i.e., 100mg)*	*Frequency (i.e., once / day)*

Name of medication	*Dosage (i.e., 100mg)*	*Frequency (i.e., once / day)*

Other Medications (over-the-counter, herbs, supplements, vitamins, minerals)

Name of medication	*Dose (i.e., 100mg)*	*Frequency (i.e., once / day)*

Name of medication	*Dosage (i.e., 100mg)*	*Frequency (i.e., once / day)*

Drug & Food Allergies

I am not allergic to any medications ☐

I am allergic to penicillin ☐ *My reaction is:* _____
I am allergic to sulfa ☐ *My reaction is:* _____
I am allergic to codeine ☐ *My reaction is:* _____

I am allergic to shellfish or iodine ☐ *My reaction is:* _____
I am allergic to latex ☐ *My reaction is:* _____

Additional medications I am allergic to	*The reaction I had was*

Foods I am allergic to include	*The reaction I had was*

Medical Conditions –indicate if you have (or had) any of the following

☐ High blood pressure	☐ Depression	☐ Arthritis	☐ Anemia
☐ High cholesterol	☐ Anxiety or panic attacks	☐ Thyroid disease	☐ Received blood transfusion
☐ Diabetes	☐ Allergies or hay fever	☐ Liver / pancreas disease	☐ Sexually transmitted disease (specify below)
☐ Heart disease or heart attack	☐ Asthma	☐ Kidney stone(s)	☐ HIV positive or AIDS
☐ Stroke	☐ Emphysema	☐ Other kidney disease	☐ Abnormal Pap (date:_____)
☐ Seizures	☐ Tuberculosis		☐ Cancer (specify type below)

Please provide additional details pertaining to your medical conditions below:

_____
_____
_____
_____
_____

Next page, please

Surgical History - indicate if and when you had any of the following

☐ Appendix – year: ☐ Gall bladder – year: ☐ Thyroid – year: ☐ Hysterectomy – year:

☐ Hernia – year: ☐ Heart – year: ☐ Lung – year: ☐ Spine or any joint – year:

☐ Tonsils – year:

Others (please describe): _____

_____

Hospitalizations

Year	*Reason*

Year	*Reason*

Social History

I drink ____ cups/glasses/cans of caffeinated coffee, tea, or soda per day

Do you smoke now: ☐ *yes* ☐ *no* *Smoked in the past:* ☐ *yes* ☐ *no*

How many years: _____ *Year quit smoking:* _____

Other tobacco products I use include:

☐ *None* ☐ *Cigars* ☐ *Chewing tobacco* ☐ *Snuff* ☐ *Other*

Alcohol usage – I drink the following number of drinks per week:

☐ *None* ☐ *1-7* ☐ *8-14* ☐ *14+*

Do you participate in recreational drug use: ☐ *yes* ☐ *no*

If so, I use: _____

My occupation is: _____

I have traveled out of the country in the last year: ☐ *yes* ☐ *no*

If so, I went to: _____

Do you have pets at home? ☐ *yes* ☐ *no*

If so, I have: ☐ *Dogs* ☐ *Cats* ☐ *Birds* ☐ *Other:* _____

Do you exercise regularly? ☐ *yes* ☐ *no*

Have you signed your driver's license as an organ donor? ☐ *yes* ☐ *no*

Family History – check where applicable (applies to blood relatives only)

	Living?	Age	High Blood Pressure	Heart Disease	Stroke	High Cholesterol	Diabetes	Cancer	Other (please list)
Father	*Yes / No*	_____	☐	☐	☐	☐	☐	☐	_____
Grandfather	*Yes / No*	_____	☐	☐	☐	☐	☐	☐	_____
Grandmother	*Yes / No*	_____	☐	☐	☐	☐	☐	☐	_____
Mother	*Yes / No*	_____	☐	☐	☐	☐	☐	☐	_____
Grandfather	*Yes / No*	_____	☐	☐	☐	☐	☐	☐	_____
Grandmother	*Yes / No*	_____	☐	☐	☐	☐	☐	☐	_____
Siblings	*N/A*	N/A	☐	☐	☐	☐	☐	☐	_____

Preventive Health – please complete the section applicable to your age and gender

Women age 40 and above: My last mammogram was done in (year): _____
Women age 50 and above: My last colonoscopy was done in (year): _____

Men age 35 and above: My last prostate exam was done in (year): _____
Men age 50 and above: My last colonoscopy was done in (year): _____

Any other information you would like us to know:

_____

_____

_____

_____

_____

All done…
Thank you!