NavicentHealth
PhysicianGroup

Dear Ms _____,

It is a pleasure to welcome you as a new patient. Thank you for allowing our doctors the chance to serve you. We value the trust you have placed in us to provide you the highest quality care.

We also believe that as a part of your health care team, we should be quick to respond to you and the doctors who have referred patients to our care. In order to meet these goals, it is vital that we have correct information on file for each of our patients. This will prevent extra forms being submitted within our business.

Please complete and bring the following papers and items to your office visit:

□ Patient Information Form	□ New Patient History Form
□ Medical Consent to Treat Form	□ Release to Family Form
□ Consent of Images, Name & Photographs	□ Patient Financial Responsibility Form
□ Central Georgia Health Exchange Form	□ CGHS Notice of Privacy Practices
□ Medication Policy	□ Authorization to Release Form

- Medical records scans/lab studies & reports (if not already sent by your referring doctor)
- Medical insurance card (s)and photo ID (if the patient is a minor child, photo ID for the parent or legal guardian is required)
- Co-pays are due at time of service. Please check with your insurance provider to ensure that services are covered.
- A list of or all current medicine

Due to increased demands of our services, **ALL OF THE ABOVE PAPERWORK MUST BE COMPLETE BEFORE ARRIVAL FOR YOUR VISIT AND YOU MUST BE ON TIME, or you will be rescheduled.** Also, we ask if you need to cancel or reschedule, please contact the office at least 24 hours before your scheduled visit time. This will allow us to give your reserved time to another patient. We do realize that emergencies happen and are not expected, so all efforts to notify us are greatly appreciated. Also, we ask that you please **limit visitors to no more than 3 (including children, who must have an adult to supervise them if needed).**

Our office is located at the **Medical Center- Navicent Health**, in the **Surgery Center, 840 Pine Street, Suite 990 (9th floor), Macon, GA 31201** (*please see included map*). Our office hours are Monday through Thursday 8:00am to 4:30pm and Friday 8:00am to 12:00pm. For your convenience, please use the RED deck on Pine Street for parking *(bring parking ticket to our office for validation)*.

We look forward to meeting you on your scheduled appointment date:

_____

If there are any questions or concerns, please do not hesitate to call us at 478-633-0404.

Sincerely,

PerinatalAssociates
NavicentHealth

NavicentHealth Physician Group
Patient Information Form

PATIENT INFORMATION

Today's date _____ **Referring Physician** _____ **Primary Physician** _____

Patient Name _____
First *Middle* *Last*

Date of Birth _____ Social Security Number _____ ☐ Male ☐ Female

Address _____

City _____ State _____ Zip _____ County _____

Phone Number _____
Home ***Cell*** ***Work***

Email Address _____

Race (Circle) Asian, American Indian, African American, White, Hispanic, Other **Primary Language (Circle)** English, Spanish, Indian, Other **Ethnicity (Circle)** Hispanic, Non-Hispanic, Refused to Report

RESPONSIBLE PARTY

First *Middle* *Last* *Relationship to Patient*

Date of Birth _____ Social Security Number _____ ☐Male ☐Female

Employer Name _____ Employer Number _____

Employer Address _____
City *State* *Zip*

Phone Number _____
Home ***Cell*** ***Work***

EMERGENCY CONTACT

1) Name _____ Ph. Number _____ Relationship _____

2) Name _____ Ph. Number _____ Relationship _____

INSURANCE INFORMATION: PLEASE PROVIDE COPIES OF ALL MEDICAL INSURANCE CARDS

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Carrier Name	*Insurance Carrier Name*
Policy Number *Group Number*	*Policy Number* *Group Number*
Claims Mailing Address _____ *Phone Number*	*Claims Mailing Address* _____ *Phone Number*
Cardholder's Name _____ *Cardholder's SSN* *DOB*	*Cardholder's Name* _____ *Cardholder's SSN* *DOB*
Cardholder's Employer	*Cardholder's Employer*

INCIDENT INFORMATION

If you plan to file other insurance please provide supporting documentation

☐ **Workers Compensation** ☐ **Liability** ☐ **Auto Insurance** ☐ **No Auto Coverage**

RELEASE OF PROTECTED HEALTH INFORMATION

Unless you give written permission we will not release you medical information according to the HIPPA guidelines. If you have someone who you want us to release your protected health information to such as a spouse, child, or parent please list (please note if you are requesting the release of medical records you will have to complete a Release of Information Form as this will only authorizes verbal communication):

Name: _____ Relationship to you: _____

Name: _____ Relationship to you: _____

Signature of Patient, Parent or Guardian: _____ Date

PerinatalAssociates
NavicentHealth

Patient Name: _____ Today's Date: _____/_____/_____

DOB: _____/_____/_____ Age _____

What is your occupation? _____

What is the name/age of the father of this baby? _____, Age_____

What is the occupation of the father of this baby? _____

Are you and the father of this baby blood relative (example: cousins)? ☐ Yes ☐ No

OBSTETRIC HISTORY

# of Total Pregnancies (including this one)	# of Full Term Deliveries (37 weeks or more)	# of Preterm Deliveries (20-37 weeks)	# of Voluntary abortions	# of Miscarriages (below 20 weeks)	# of Ectopic (Tubal) pregnancies	# of Multiple Births (twins, triplets, etc)	# of Living Children

Have you EVER experienced any of the following THIS pregnancy:		
☐ Yes	☐ No	Vaginal bleeding
☐ Yes	☐ No	Preterm labor
☐ Yes	☐ No	Cerclage placement
☐ Yes	☐ No	Other- specify:

Please fill in the table below for all pregnancies, living or deceased, starting with the first.

Year	Weeks	Birth Wt LB. / OZ.	Sex	Type of Delivery (vag, C/S, D&C)	Anesthesia (epidural/spinal, IV meds, general-put to sleep)	Hospital	Complications (preterm labor, preeclampsia, IUGR, gestational diabetes, preterm rupture of membranes)
		lbs oz					
		lbs oz					
		lbs oz					
		lbs oz					
		lbs oz					
		lbs oz					
		lbs oz					
		lbs oz					

Patient Initials: _____

SURGICAL HISTORY

Any Previous Surgeries? (Include minor or outpatient surgeries such as wisdom tooth removal, D&C, C-Sections, etc.) ☐ None			
Year	**Procedure**	**Hospital**	**Reason for surgery**

MEDICATIONS

Please list all Current or Past Medications ☐ None				
Name	**Strength**	**How many times a day?**	**For how long?**	**Still using? If not, when did you stop?**

ALLERGIES

Any allergies to medications? ☐ Yes (please list below) ☐ No	
Medication	**Reaction**

Allergic to Latex? ☐ Yes ☐ No

Allergic to Shellfish (shrimp, crab, lobster)? ☐ Yes ☐ No

Patient Initials: _____

MEDICAL HISTORY

Do YOU have, or have you had, any of the following conditions:			
☐ Yes	☐ No	Asthma	
☐ Yes	☐ No	Tuberculosis (TB)	
☐ Yes	☐ No	Cystic Fibrosis	
☐ Yes	☐ No	Irregular Heart Beat	
☐ Yes	☐ No	Heart Attack	
☐ Yes	☐ No	Heart Disease	
☐ Yes	☐ No	Cardiomyopathy	
☐ Yes	☐ No	High Blood Pressure outside of pregnancy	
☐ Yes	☐ No	Bowel disorder (IBS, Crohns, Ulcerative colitis)- (Please circle)	
☐ Yes	☐ No	Hepatitis / Liver disease- Please specify:	
☐ Yes	☐ No	Bladder infections / UTI (urinary tract infection)	
☐ Yes	☐ No	Kidney stones	
☐ Yes	☐ No	Kidney infection / Pyelonephritis	
☐ Yes	☐ No	Kidney disease	
☐ Yes	☐ No	Herpes	
☐ Yes	☐ No	Pelvic Inflammatory Disease	
☐ Yes	☐ No	Gonorrhea	
☐ Yes	☐ No	Chlamydia	
☐ Yes	☐ No	Syphilis	
☐ Yes	☐ No	Genital Warts	
☐ Yes	☐ No	HIV Infection / AIDS	
☐ Yes	☐ No	Abnormal PAP Smear	
☐ Yes	☐ No	Diabetes (High Blood Sugar) outside of pregnancy	
☐ Yes	☐ No	Uterine malformation- Please specify:	
☐ Yes	☐ No	Fibroids	
☐ Yes	☐ No	Thyroid Problems (hypothyroidism, hyperthyroidism)- (Please circle)	
☐ Yes	☐ No	Epilepsy / Seizure Disorder	
☐ Yes	☐ No	Migraines	
☐ Yes	☐ No	Depression	
☐ Yes	☐ No	Anxiety / Panic attack disorder- (Please circle)	
☐ Yes	☐ No	Eczema	
☐ Yes	☐ No	Arthritis	
☐ Yes	☐ No	Lupus	
☐ Yes	☐ No	Sickle Cell Trait or Disease- (Please circle)	
☐ Yes	☐ No	Thalassemia- Please specify:	
☐ Yes	☐ No	Bleeding Disorder/ Hemophilia- Please specify:	
☐ Yes	☐ No	Blood Clots / DVT / Pulmonary embolus (PE)- (Please circle)	
☐ Yes	☐ No	Thrombophilia (Clotting disorder)- Please specify:	
☐ Yes	☐ No	Thrombocytopenia	
☐ Yes	☐ No	Cancer- Please specify:	
☐ Yes	☐ No	Rh Sensitized	
☐ Yes	☐ No	Blood Transfusions	If yes, Date and Reason:

Any other major medical problems?- Please specify: _____

_____

Patient Initials: _____

SOCIAL HISTORY

Do you drink alcohol? ☐ Yes ☐ No

- If yes, how often during the pregnancy? _____

- How often before pregnancy? _____

Have you EVER used any street drugs? ☐ Yes ☐ No

-If yes, is it current or past? _____ Type of drug _____

Do you smoke? ☐ Yes ☐ No

- If yes, how many packs per day? _____ How many years? _____

- If you smoked in the past, when did you quit? _____

PLEASE READ AND SIGN BELOW

I certify the information given above by me is correct. I understand an ultrasound examination cannot rule out all anatomic abnormalities or genetic syndromes.

Signature of Patient_____ **Date** _____

Reviewed by_____
Provider signature

NavicentHealth
PhysicianGroup

Images and Video Consent Form

I, _____ (name, surname),

_____ (relationship to patient) hereby consent to medical images and/ or video being made of me/ my child/ my dependent/ the patient.

I agree that the images and results of my investigative tests may be:

a) Placed in my medical record for future reference and /or treatment
b) Used by health professionals for teaching and training purposes
c) Used in paper or electronic health publication
d) I agree that the pictures have been shown to me

	YES	NO
a		
b		
c		
d		

By signing below, I confirm that I understand this consent form. No fees will be paid.

_____ _____

Signature of Patient **Date**

_____ _____

Signature of Parent/ Responsible Party **Date**

_____ _____

Signature of Physician/Health Professional **Date**

Patient's name and hospital number will not be revealed or published. Anonymity will be pursued and facial features will be disguised where possible. Material will not be used for advertising.

CENTRAL GEORGIA HEALTH SYSTEM
NOTICE OF PRIVACY PRACTICES

Notice of Privacy Practices

I have been offered a copy of the Central Georgia Health System notice of Privacy Practices.

_____ _____
Patient Signature Date

_____ _____
Witness Date

Comments: _____

_____

_____

_____

Central Georgia Health System

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

The Medical Center of Central Georgia
Health Information Management MSC #148
777 Hemlock Street
Macon, GA 31201-1202

I authorize and request the disclosure of protected information FROM:

- ☐ Medical Center of Central Georgia
- ☐ WT Anderson Health Center
- ☐ Childrens Hospital
- ☐ Med Center North
- ☐ Med Center East
- ☐ Med Center Northwest
- ☐ Other (specify):_____
- ☐ Central Georgia Rehabilitation Hospital
- ☐ Central Georgia Home Health
- ☐ Central Georgia Wound Care
- ☐ Hospice of Central Georgia
- ☐ Sibley Heart Center
- ☐ Clinic/Physician Practice (specify):
  _____

to release health information about the following patient: **MR#**_____
(Office Use)

_____ _____
Print Patient Name: Date of Birth

_____ _____
Street Address Telephone Number

_____
City, State and Zip Code

I expressly request that the information in the designated record set be disclosed for date(s) of treatment: _____ to include the following:

☐ Abstract – History & Physical, Consultations, Discharge Summary, Operative Report, Lab Reports, Radiology Reports, Other Diagnostic Reports, Emergency Center Physician Dictation

☐ Continuity Care Documents – Diagnostic Test Results, Problem List, Medication Lists, Medication Allergies, Discharge Summary, Procedures

- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Consultations
- ☐ Operative Reports
- ☐ Pathology Reports
- ☐ Outpatient Rehab Records
- ☐ Lab Reports
- ☐ Radiology Reports
- ☐ EKG
- ☐ Emergency Center
- ☐ Progress Notes
- ☐ Health Center / Clinic
- ☐ Physicians' Orders
- ☐ Cardiovascular Reports
- ☐ Urgent Care Records
- ☐ Hospice Records
- ☐ Discharge Instructions
- ☐ Other (specify):
  _____

This protected health information is disclosed for the following purpose(s):

- ☐ Insurance
- ☐ Continued Treatment
- ☐ Legal
- ☐ Patient's / Representative's Request
- ☐ Other (specify):_____

You are authorized to release the above records TO the following:

_____
Name Title

_____
Street Address

_____
City, State and Zip Code

By Delivery Method: ☐ US Postal Service ☐ Pick – up ● Electronic Delivery ☐ Patient Portal ☐ USB ☐ Healthport Portal

Central Georgia Health System

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I understand the following:

a) I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization and submitted to The Medical Center of Central Georgia, HIM Department, 777 Hemlock, Hosp. Box 148, Macon, and GA 31201. The revocation will not affect any actions taken before the receipt of the written revocation.

b) My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

CGHS healthcare entities and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), psychological or psychiatric conditions, and/or alcohol and drug abuse. I authorize the release or disclosure of this type of information.

_____ _____

Signature of Patient or Legal Authorized Representative **Date**

I understand that this authorization will expire in 90 days from the date of execution of this authorization unless I otherwise specify. I desire this authorization to be in effect until

_____.

Expiration date and/or event

_____ _____

Signature of Patient or Legal Authorized Representative **Date**

_____

Print Name

_____ _____

Relationship if other then patient **Street Address**

_____ _____

Telephone Number **City, State and Zip Code**

Office Use

☐ Legal authorized representative proof obtained and attached to this authorization

Z26167 02/03 09-12(rev.) h/t

Central Georgia Health System

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

The Medical Center of Central Georgia
777 Hemlock St. MSC 148
Macon, GA 31201

The release of patient information is governed under Federal and Georgia state statutes. Requests for information can be granted only with a valid authorization. All sections of the authorization must be completed for records to be released.

In order to verify your identification and validate your authorization, we require that you include a legible copy of a valid photo I.D. (e.g., driver's license, military I.D. or state I.D.)

At your request, we can send a copy of your record (s) to your physician without cost. You must provide the full name, address, telephone number, and fax number (if applicable) of the physician on the authorization.

For personal copies of your record (s), please see the information below regarding fees that will be charged based on Georgia Code Annotated 33-33-3. If you believe the record (s) you are requesting may exceed a certain dollar amount and would like us to notify you in advance, please indicate in the area below marked "Fee Approval".

$.97 per page for pages 1-20
$.83 per page for pages 21-100
$.66 per page for pages 100+

FEE APPROVAL:
Please notify me if the cost of my records exceeds $ _____.

By my signature below, I acknowledge that I am aware of the fee for copies of medical records. I agree to pay this fee when I received an invoice from HealthPort.

Please Print:
Name: _____

Address: _____
Street **City** **State** **Zip**

Phone: _____
Area Code **Phone Number**

_____ _____
Signature **Date**

Z26167 02/03 09-12(rev.) h/t

NavicentHealth
Physician Group

Medicare Secondary Payer Questionnaire

Are you currently employed?

- ○ No, currently not employed
- ○ No, never employed
- ○ No, retired –Date of retirement _____
- ○ Yes currently, employed

If married, is your spouse currently employed?

- ○ No, currently not employed
- ○ No, never employed
- ○ No, retired- Date of retirement_____
- ○ Yes, currently employed- **Complete all fields below**

Organization Name:			
Street :	City:	State:	Zip:

Yes	No	
○	○	Do you have group health plan (GHP) coverage based on your own or a spouse's current employment or a family member's current employment? (**Complete Section A below**)
○	○	Does the employer that sponsors your health plan employ 20 or more persons?
○	○	Is this visit associated with a **work injury/illness**? (**Complete Section B below**)
○	○	Is this visit associated with a **non-work related accident**? (**Complete Section C below**)
○	○	Are you receiving **Black Lung** benefits? (Black Lung is primary for claims related to Black Lung)
○	○	Are services to be paid by a **government program**, such as a research grant?
○	○	Has the **Department of Veterans Affairs** agreed to pay for care at this facility?
○	○	Are you eligible for Medicare because of **disability**?
○	○	Are you eligible for Medicare because of **end stage renal disease**? (**Complete Section D below**)

SECTION A

Group Health Plan- (Must be completed if you are covered by a group health plan).

Insurer: _____ Policy Holder:_____

Relationship:_____

Policy ID#_____ Membership #:_____

Group ID#_____

SECTION B

If Work related illness:

Date of injury:	Worker's Compensation plan:
Policy/ID number:	Employer Name:

SECTION C

Non-work Related Illness/Injury

Type of accident: ____Auto ____Non Auto

Date of accident:_____

No-Fault Insurance (No- fault insurance is insurance that pays for health care services resulting from injury to you or
damage to your property regardless of who is at fault for causing the accident.)

Is No-Fault insurance available? ○Yes ○No

Insurer:_____

Claim Number:_____

Liability Insurance (Liability insurance is insurance that protects against claims based on negligence, inappropriate action or inaction, which results in injury to someone or damage to property.)

Is Liability insurance available? ○Yes ○No

Insurer:_____

Claim number:_____

SECTION D

End Stage Renal Disease Benefits

Yes	No	
○	○	Have you received a kidney transplant? Date of transplant_____
○	○	Have you received maintenance dialysis treatment? Date dialysis began_____
○	○	Did you participate in a self-dialysis training program? Date training began_____
○	○	Are you within the 30 month coordination period?
○	○	Was you initial entitlement to Medicare based on ESRD?
○	○	Are you entitled to Medicare on the basis of **either** ESRD and age **or** ESRD and disability?
○	○	Does the working aged or disability MSPQ provision apply (ie. is the GHP already primary based on age or disability entitlement?

60 Day Rule

Have you been an inpatient in a hospital or skilled nursing during the prior 60 days?

Name of facility:

Dates of Stay from _____ to _____

Length of stay

Information Provided by:

Name:_____

Relationship to patient: _____

Campus Map

TheMedicalCenter
NavicentHealth

For easier access to services, park in decks that correspond to the following colors:

The Lanier Building

Center for Ambulatory Services

Central Georgia Breast Care Center

Endoscopy Center

Peyton Anderson Health Education Center

The Children's Hospital

1916 Building

The Surgery Center

840 Pine Street Professional Building

The Emergency Center

770 Pine Professional Building

W.T. Anderson Health Clinic

West Tower

Main Tower & Entrance

East Tower

Gift Garden

Bridge access on 3rd floor to Family Birth Center

The Albert Luce, Jr. Heart Institute

Patient Registration

East Tower