THOMASTON MEDICAL CLINIC, PC

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WELCOME TO OUR PRACTICE!!!!

Dear Patient,

We are honored that you have chosen our office for your healthcare needs. We look forward to the opportunity to serve you.

I have enclosed the paperwork you need to fill out completely before your appointment. Also, I am including a copy of our office's financial policy for your review. If you have any questions about the enclosed paperwork, please feel free to call our office for assistance.

Please bring this paperwork, along with your insurance card(s), picture ID, and all medications you take in the bottles they were given to you into your appointment.

***A missed appointment without notification to our office (*No Show*) or cancellation on the same day of your appointment will result in a

$25 late-cancellation/no-show fee.

Again, we look forward to seeing you on_____at_____am/pm.

Yours truly,
Christy Winkles, CPPM
Practice Administrator

PATIENT DEMOGRAPHIC INFORMATION

Date_____ Patient Name (First, MI, Last)_____
SSN_____ _____Male_____ Female Date of Birth_____
Address_____ City_____ State_____ Zip_____
Phone #_____ ___Minor ___Single ___Married ___Divorced ___Widowed
Employer_____ Phone #_____
Address_____ City_____ State_____ Zip_____
Spouse/Parent Name_____ Employer_____
Home Phone #_____ Work Phone #_____
Person to contact in case of emergency _____ Phone #_____
Email (for Patient Portal invitation) _____

RESPONSIBLE PARTY (if other than patient)

Name_____ Relationship to Patient_____
Address _____ Phone #_____
Birthdate_____ SSN_____
Employer_____ Work Phone #_____

INSURANCE INFORMATION (Please present card to receptionist for copy)

Name of Insured_____ Relationship to Patient_____
Date of Birth_____ SSN_____ Employer_____
Name of Insurance_____ ID#_____
Address_____ Phone #_____
**Do you have additional insurance? ___yes ___no If yes on additional insurance, please complete the following:
Name of Insured_____ Relationship to Patient_____
Date of Birth_____ SSN_____ Employer_____
Name of Insurance_____ ID#_____

I authorize release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the provider.

X_____ _____
Signature of Patient or Parent (if minor) Date

I have received, read, and understand the *Notice of Privacy Practices* containing a complete description of the uses and disclosures of my health information as required by the Health Insurance Portability & Accountability Act of 1996 ("HIPAA").

X_____ _____
Signature of Patient or Parent (if minor) Date

FORM COMPLETION POLICY: Completion of paperwork/forms (FMLA, disability, handicap parking, etc.) outside an office visit will require a $50.00 fee per form or more, due when form is picked up. Please allow 7-10 business days for completion of forms.

NO SHOW POLICY: Any patient who fails to show or cancel/reschedule an appointment and has not contacted our office will be considered a *No Show* and will be charged $25.00 fee per occurrence. The fee is charged to the patient, not the insurance company, and is due prior to the patient's next office visit. As a courtesy, we make reminder calls for appointments. If you do not receive a reminder call or message, the NO SHOW policy will remain in effect.

HEALTH HISTORY

PATIENT NAME _____ BIRTHDATE____/____/____ PATIENT #_____

To help us meet all your healthcare needs, please fill out this form completely in ink. This is a confidential record of your medical history and will be kept in this office.

Today's Date_____
Place of Birth_____
Highest Level in School _____
Occupation_____
Previous Occupations_____
Marital Status_____
Hobbies_____
Exercise/Recreation_____
Habits:
Smoking (type & amount per day)_____
If former smoker, date quit_____
Alcohol (type and amount per week)_____
Caffeine (type & amount per day)_____
Street Drugs (type and amount per day)_____
Usual Weight_____
Date of Last Dental Exam_____
Please list all allergies (foods, drugs, environment)
_____
_____
_____

When was your last physical exam?_____
Name of Doctor_____ Phone_____
Please list all serious illnesses, operations, and other hospitalizations you have experienced and indicate year these occurred: ☐ None
_____
_____
_____
_____

Please list all medicines you are currently taking (include nonprescription drugs): ☐ None
_____
_____
_____

Describe all serious accidents, severe injuries, head injury, fractures, or broken bones (include date occurred): ☐ None
_____
_____
_____
_____

CHIEF COMPLAINTS

Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:

_____
_____

PAST MEDICAL HISTORY

Have you ever had the following: (Circle "No" or "Yes", leave blank if uncertain)

Measles	No	Yes	Migraine Headaches	No	Yes	Hives or Eczema	No	Yes
Mumps	No	Yes	Tuberculosis	No	Yes	AIDS or HIV+	No	Yes
Chickenpox	No	Yes	Diabetes	No	Yes	Infectious Mono	No	Yes
Whooping Cough	No	Yes	Cancer	No	Yes	Bronchitis	No	Yes
Scarlet Fever	No	Yes	Polio	No	Yes	Mitral Valve Prolapse	No	Yes
Diphtheria	No	Yes	Glaucoma	No	Yes	Stroke	No	Yes
Smallpox	No	Yes	Hernia	No	Yes	Hepatitis	No	Yes
Pneumonia	No	Yes	Blood or Plasma Transfusions	No	Yes	Ulcer	No	Yes
Rheumatic Fever	No	Yes	Back Trouble	No	Yes	Kidney Disease	No	Yes
Heart Disease	No	Yes	High or Low Blood Pressure	No	Yes	Thyroid Disease	No	Yes
Arthritis	No	Yes	Hemorrhoids	No	Yes	Bleeding Tendency	No	Yes
Venereal Disease	No	Yes	Date of Last Chest X-Ray_____			Any Other Disease	No	Yes
Anemia	No	Yes	Asthma	No	Yes	(please list)_____		
Bladder Infections	No	Yes				_____		
Epilepsy	No	Yes				_____		

FAMILY HISTORY

Has any blood relative had any of the following: (Circle "No" or "Yes", leave blank if uncertain)

			RELATIONSHIP				RELATIONSHIP
Cancer	No	Yes	_____	Stroke	No	Yes	_____
Tuberculosis	No	Yes	_____	Epilepsy	No	Yes	_____
Diabetes	No	Yes	_____	Allergies	No	Yes	_____
Heart Disease	No	Yes	_____	Anemia	No	Yes	_____
High Blood Pressure	No	Yes	_____	Bleeding Tendency	No	Yes	_____

HEALTH HISTORY (Continued)

PATIENT NAME _____ BIRTHDATE____/____/____ PATIENT #_____

FAMILY HISTORY (Continued): (Circle "No" or "Yes", leave blank if uncertain)

			RELATIONSHIP	**PRESENT AGE, OR AGE OF DEATH**	**IF LIVING, HEALTH STATUS (Good, Fair, Poor). IF DECEASED, CAUSE OF DEATH.**
Asthma	No	Yes	_____	Father:	
Chronic Lung Disease	No	Yes	_____	Mother:	
Drug or Alcohol Problem	No	Yes	_____	Siblings:	
Mental Illness	No	Yes	_____		
Leukemia	No	Yes	_____		
Migraine Headaches	No	Yes	_____		
Obesity	No	Yes	_____		
Thyroid Disease	No	Yes	_____	Spouse:	
Ulcer	No	Yes	_____	Children:	
Depression	No	Yes	_____		
High Cholesterol	No	Yes	_____		
Kidney Disease	No	Yes	_____		
Glaucoma	No	Yes	_____		
Gout	No	Yes	_____		

Do you have now or have you had within the past year: (Circle "No" or "Yes", leave blank if uncertain)

Weakness or Paralysis	No	Yes	Bloody Sputum	No	Yes	Joint Pain or Stiffness	No	Yes
Tire Easily or Weakness	No	Yes	Wheezing	No	Yes	Swollen Joints	No	Yes
Recent Weight Changes	No	Yes	Chest Pain or Discomfort	No	Yes	Muscle Cramps or Spasms	No	Yes
Change in Appetite	No	Yes	Purple Fingers or Lips	No	Yes	Sleeplessness	No	Yes
Sensitivity to Cold or Heat	No	Yes	Swelling of Hands, Feet, Ankles	No	Yes	Seizures	No	Yes
Persistent Fever	No	Yes	Difficulty in Breathing	No	Yes	Depression	No	Yes
Night Sweats / Hot Flashes	No	Yes	Palpitations / Fluttering of Heart	No	Yes	Memory Loss	No	Yes
Skin Rash	No	Yes	Leg Cramps on Walking or at Night	No	Yes	Poor Coordination	No	Yes
Skin Trouble or Changes	No	Yes	Enlarged Veins	No	Yes	Dizziness / Fainting Spells	No	Yes
Change in Nails or Hair	No	Yes	Difficulty Swallowing	No	Yes	Living Will / Advance Directive	No	Yes
Headaches	No	Yes	Heartburn	No	Yes	**Men Only:**		
Easy Bleeding or Bruising	No	Yes	Frequent Belching	No	Yes	Discharge from Penis	No	Yes
Double Vision	No	Yes	Abdominal Cramping	No	Yes	Pain or Lump in Testicles	No	Yes
Blurred Vision	No	Yes	Nausea	No	Yes	Impotence	No	Yes
Eye Pain	No	Yes	Vomiting	No	Yes	**Women Only:**		
Infected Eyes	No	Yes	Vomited or Coughed up Blood	No	Yes	Age Period Began _____		
Do you wear glasses/contacts	No	Yes	Chronic Diarrhea	No	Yes	How many days do periods last?_____		
When was your last eye exam?_____			Chronic Constipation	No	Yes	How many days between periods?_____		
Ringing in the Ears	No	Yes	Rectal Bleeding	No	Yes	Is the Flow Heavy?	No	Yes
Discharge from Ears	No	Yes	Black Tarry Stools	No	Yes	Do you bleed/spot between periods?	No	Yes
Ear Pain	No	Yes	Dark Urine	No	Yes	Do you have pain / cramps?	No	Yes
Decrease in Hearing	No	Yes	Yellow Jaundice	No	Yes	Date of Last Period?_____		
Frequent Nosebleeds	No	Yes	Frequent Urination (Day)	No	Yes	Date of Last Pelvic Exam?_____		
Frequent Colds	No	Yes	Frequent Urination (Night)	No	Yes	Date of Last Mammogram?_____		
Sinus Trouble	No	Yes	Increase in Thirst	No	Yes	Any itching in vaginal area?	No	Yes
Loss of Smell	No	Yes	Painful Urination	No	Yes	Pain with Intercourse	No	Yes
Persistent Hoarseness	No	Yes	Leakage of Urine	No	Yes	Type of Birth Control Used?_____		
Sore Throat	No	Yes	Difficulty in Starting Urine	No	Yes	Number of Pregnancies_____		
Sore Tongue or Gums	No	Yes	Blood in Urine	No	Yes	Number of Full Term Births_____		
Lump / Discharge from Breast	No	Yes	Lack of Sex Drive	No	Yes	Number of Preterm Births_____		
Chronic or Frequent Cough	No	Yes	Hemorrhoids	No	Yes			
Shortness of Breath	No	Yes	Backaches	No	Yes			

X_____ _____

Signature of Patient or Parent (if minor) Date

THOMASTON MEDICAL CLINIC, PC

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS

Many of our patients allow family members such as spouses, children, siblings, parents, grandchildren or others to call and discuss medical information, request prescriptions, medical records, results of tests, pickup forms, etc. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have any of your medical information released to anyone, you must sign this form. Signing this form will only give consent to release said information to the individuals indicated below.

YOU HAVE THE RIGHT TO REMOVE THIS AUTHORIZATION AT ANY TIME BY REQUESTING IN WRITING.

I, _____, date of birth _____
authorize representatives of Thomaston Medical Clinic, PC to share and/or release information to:

1) _____ Relationship _____
Check all that apply:
□ Regarding appointment, time & date □ Discuss test results □Discuss billing issues
□ Discuss medical care, an issue or concern □ Request and pick up prescriptions/forms

2) _____ Relationship _____
Check all that apply:
□ Regarding appointment, time & date □ Discuss test results □Discuss billing issues
□ Discuss medical care, an issue or concern □ Request and pick up prescriptions/forms

3) _____ Relationship _____
Check all that apply:
□ Regarding appointment, time & date □ Discuss test results □Discuss billing issues
□ Discuss medical care, an issue or concern □ Request and pick up prescriptions/forms

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I understand that I have the right to change this authorization, in writing, at any time by sending a written notification to this office.

_____ _____
Patient Name (Printed) **Date**

_____
Patient Signature

If you think we may have violated your privacy rights or if you disagree with any action we have taken regarding your health information, we want you or your family to speak with us. If you complain to us, your care will not be affected in any way. It is our goal to give you the best care while respecting your privacy.

Thomaston Medical Clinic, PC Management

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 & Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in and 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. HIPPA provides penalties for covered entities that misuse personal health information.

As required by HIPPA, 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.
We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

*Treatment means providing, coordinating, or managing heal care and related services by one or more health care providers. An example of this would include examination.

*Payment means 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 our 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.
Any other uses and disclosures will be made only with you written authorization. You may revoke such authorization in writing, and 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.

You have the following rights with respect to you protected health information, which you can exercise by presenting a written request to the Privacy Officer:

*Request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other persons 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.

*Reasonable requests to receive confidential communications of protected health information from us by alternative mean or at alternative locations.

*Inspect and copy your protected health information.

*Amend your protected health information.

*Receive an accounting of disclosures of protected health information.

*Obtain a paper copy of this notice from us upon request.

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

This notice is effective as of April 1, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaints with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice and the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information or to file a written complaint:

Thomaston Medical Clinic, PC Christy Winkles, Privacy Officer 615 South Center Street Thomaston, Georgia 30286 706-647-2147	The U.S Department of Health & Human Services Office of Civil Rights 200 Independence Avenue, SW Washington, DC 20201 202-619-0257 Toll Free: 1-877-696-6775

Most recent review and update: December 29, 2022

TMC PATIENT BILLING AND FINANCIAL POLICY

The staff of Thomaston Medical Clinic are happy to welcome you to our facility and are dedicated to providing you with the very best medical care with a pleasant experience. We have developed the following financial policies to avoid any miscommunications about the expectation for bills and accounts.

1. **Health Insurance**:

If you will be using health insurance for your services, please present your current card upon check-in. It is our policy to collect any applicable deductible, co-insurance, or co-payments due at the time service is rendered. We will gladly file a claim on your behalf based on the information you provide to us. You will be responsible for services you receive that your health insurance plan does not cover including out of network charges. ***Money collected is an estimate only***.

2. **Self-Pay or Uninsured**:

If you will be paying for your services yourself, you will be expected to pay at the time of service. If any additional services or tests are provided during your visit above and beyond the office charges, you will be expected to pay those upon completion of your visit. A good faith estimate of your expected charges based on information available at the time of scheduling your appointment is available upon request/scheduling.

3. **Workers' Compensation**:

If you need to see a physician for an injury or illness related to employment, your appointment MUST be made by your employer or workers' compensation case manager. We will need to have the case number as well as all billing information before your appointment.

Acceptable forms of payment include cash, check, money order, or debit/credit card. Thomaston Medical Clinic will charge a returned check fee of $30 for any returned check returned by your bank for non-payment.

Thomaston Medical Clinic will send you an itemized billing statement listing each service that you are being billed for, payments and/or adjustments from your insurance company, and any balance due. Patients with a personal balance will receive a monthly statement showing specific amounts due. Statements are not sent until insurance claims have processed. These statements are due upon receipt. Any payments received/posted after a dated billing statement will reflect on the next statement unless balance is paid in full.

Patients with delinquent accounts will be required to make payment at time of service. If you are unable to make mutually agreeable payment arrangements at that time, we will be glad to reschedule your appointment to a time when you will be able to make such arrangement.
If your account is referred to collection status, you must pay all past due amounts before your next appointment with Thomaston Medical Clinic providers.

If you have any questions or concerns regarding your account or insurance claim, please contact our billing department.