Dr. Claire L. Visitacion
323 Resource Parkway
Winder, GA 30680
T- (678)975-7471/ F-(678)975-7055
www.bethlehemdoc.com

PATIENT INFORMATION:

First Name: _____ MI: _____ Last Name: _____ DOB: ____/____/_____
SSN: ____-____-_____ Gender:_____ Marital Status: _____ Race: _____
Home Address: _____ City: _____ State: ____ Zip: _____
Mailing Address (if different from above): _____
Home Phone: (_____)_____ Cell: (_____)_____ Email: _____
Living Will? Yes ___ No___ Advanced Directive? Yes ___ No ___ Power of Attorney? Yes ___ No ___

GUARDIAN OR RESPONSIBLE PARTY INFORMATION:

Name: _____ Relationship to Patient: _____
SSN: ____-____-_____ DOB: ____/____/_____ Gender:_____ Phone Number: (_____)_____
Home Address: _____ City: _____ State: ____ Zip: _____
Employer: _____ Work Phone Number: (_____)_____

EMERGENCY CONTACT:

Name: _____ Relationship: _____ Phone Number: (_____)_____
Name: _____ Relationship: _____ Phone Number: (_____)_____

INSURANCE INFORMATION:

Primary: _____ Policy #: _____ Group #: _____ Group Name: _____
Name & Relationship: _____ DOB: ____/____/_____ SSN: ____-____-_____
Secondary: _____ Policy #: _____ Group #: _____ Group Name: _____
Name & Relationship: _____ DOB: ____/____/_____ SSN: ____-____-_____
Tertiary: _____ Policy #: _____ Group #: _____ Group Name: _____
Name & Relationship: _____ DOB: ____/____/_____ SSN: ____-____-_____

PREFERRED PHARMACY INFORMATION:

Pharmacy Name: _____ Pharmacy Phone Number: (_____)_____
Pharmacy Address: _____ City: _____ State: ____ Zip: _____

***I authorize Bethlehem Family Healthcare to obtain my prescription electronically*.** **Yes ___ No___**

I certify that the above information is correct. I consent to be treated by the staff and providers of Bethlehem Family Healthcare. I authorize payment of medical benefits to Bethlehem Family Healthcare, and authorize them to release any medical information necessary to process claims. I understand that I am responsible for co-payments, deductibles, co-insurance and non-covered services.

Patient/Guarantor signature: _____ Date: _____

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PERSONAL HISTORY

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

Describe the reason(s) for your visit today:

_____

Previous Primary Care Physician (PCP): _____

Please list all specialty physicians you are currently seeing (Cardiologist, ENT, Pulmonologist):

_____

_____

ALLERGIES: (Please list all allergies to medications and their reactions)

_____

_____

***MEDICATION LIST*:** (Please list all medications you are currently taking and their dosage)

_____

_____

_____

_____

MEDICAL HISTORY: (Please list all past or present medical conditions)

_____

_____

_____

SURGICAL HISTORY: (Please list the type of surgery, dates, and location)

Have you ever had surgery? Yes No

Surgery: _____ Date/Location: _____

Surgery: _____ Date/Location: _____

Surgery: _____ Date/Location: _____

Surgery: _____ Date/Location: _____

HOSPITALIZATIONS: (Please list dates and reason for hospitalization)

_____

_____

_____

FAMILY HISTORY: Check all that apply

	Alive	Deceased	Unknown	Medical Condition/Cause of Death
Father				
Mother				
Father's Father				
Father's Mother				
Mother's Father				
Mother's Mother				
Siblings: How many?				
Sister(s)				
Brother(s)				
Children: How many?				
Son(s)				
Daughter(s)				

SOCIAL HISTORY:

Do you wear a seat belt? Yes____ No____

Do you exercise on a regular basis? Yes ___ No ___ If yes, ____ times a week for _____ minutes.

What type of exercise(s) do you do? _____

Are you on a diet? Yes No Did a physician prescribe this diet? Yes No

Number of meals you eat on an average day? _____ Snacks: _____

Do you drink alcohol? Yes No If yes, how many drinks per day _____ Week _____

Are you a tobacco user? Yes No ____ Cigarettes ____ E-Cigarettes ____ Chew/Dip

Current smoker, how many packs per day? _____ Length of tobacco use: _____

Previous smoker, what year did you quit? _____

If you are a non-smoker, are you exposed to 2nd hand smoke? Yes No

Do you use recreational drugs such as cocaine and marijuana? Yes No

Do you have a living will? Yes No

Do you have a healthcare power of attorney? Yes No

FEMALE PATIENTS: Age at first menstrual cycle? ____ Regular? ____ Irregular?

Date of last period? ____/____/_____ Premenstrual Symptoms? _____

Time between menstrual cycles? 21 days_____ 28 days_____ Other:_____

Pregnancies: How many?_____ Deliveries: Vaginal: _____ C-Section: _____

Date of last Pap smear? ____/____/_____ Results: _____

Name of physician who performed Pap Smear _____

Have you had a hysterectomy? Yes_____ No_____ If yes, please list the date? ____/____/_____

SEXUAL HISTORY:

Are you sexually active? Yes ___ No ___ (If no, please go to the next section)

Vaginal _____ Oral _____ Anal _____ *with* Women _____ Men _____ Both _____

Do you use protection? Yes_____ No_____ If yes, what kind? _____

Have you ever been diagnosed with an STD? Yes___ No___ If yes, please list _____

PREVENTATIVE CARE:

Have you had a mammogram done? Yes___ No___ Date: ____/____/_____ Results: _____

Have you had a colonoscopy done? Yes___ No___ Date: ____/____/_____ Results: _____

Have you seen a dentist and eye doctor within the past 12 months? Yes No

Dentist's name: _____

Eye Doctor's name: _____

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient's Name: _____ DOB: _____/_____/_____

I wish to be contacted in the following manner: (Check all that apply)

Home Telephone: (_____)_____-_____ Is it okay to leave a message? Yes No

Cell Phone: (_____)_____-_____ Is it okay to leave a message? Yes No

Work Telephone: (_____)_____-_____ Is it okay to leave a message? Yes No

In the event I cannot be reached, I _____, give permission for a representative from Bethlehem Family Healthcare to share information regarding care, appointments, billing information, and/or test results with the individual(s) listed below.

Name: _____ Relationship: _____ Phone: (_____)_____-_____

Name: _____ Relationship: _____ Phone: (_____)_____-_____

Name: _____ Relationship: _____ Phone: (_____)_____-_____

I have received a copy of Bethlehem Family Healthcare's Notice of Privacy Practices and have read and understood its contents. I ultimately agree that Bethlehem Family Healthcare may disclose any and/or all of my PHI/Medical Records to any person and/or facility they deem necessary.

Patient/Guarantor Name (Printed): _____ Date: _____

Patient/Guarantor Signature: _____

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MEDICAL RECORDS RELEASE FORM

Patient's Name: _____ DOB: _____/_____/_____

I do hereby request my complete personal protected health information/medical records to be released in their entirety to Bethlehem Family Healthcare (Dr. Claire L. Visitacion and staff) from the following organization:

Name of Facility/Office: _____ Phone Number: (_____)_____

Address: _____ City: _____ State: _____ Zip: _____

The type of information to be used or disclosed is as follows:

Starting Date of Service(s): _____ Ending Date of Service(s): _____

( ) Complete Medical Records
( ) History & Physical
( ) Discharge Summary
( ) Operative Report
( ) Consultation Reports
( ) X-ray/Imaging Reports
( ) Progress Notes
( ) Laboratory Test Results
( ) Immunization Records
( ) Other _____

I understand that information in my health record may include information relating to confidential information and may include mental health, alcohol and drug use information. I also authorize the release of these information.

I understand that by signing this authorization, I am giving Bethlehem Family Healthcare permission to release my complete personal protected health information/medical records. I understand that my complete health information may be related to any of the following but not limited to: Specialty Physicians, PCP, Hospital (of choice), Lab Companies, Pharmacy, Home Healthcare Facility, Nursing Home, Insurance Company and Medical Supply Company (of choice).

I understand that information disclosed under this authorization may be subject to redisclosure by the recipient of such information and the information may no longer be protected under the terms of this authorization or by the federal privacy laws.

I understand that this authorization may be revoked at any time. This must be in writing to the office. This would not apply to information that has already been released prior to my written revocation. I also understand that I may refuse this authorization.

Patient/Guarantor Name (Printed): _____ Date: _____

Patient/Guarantor Signature: _____

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Financial Policies

We are dedicated to providing the best possible care for you and we want you to completely understand our financial policies.

1. Due to our contractual agreements with insurance companies and State Law, all co-pays **MUST** be collected at the time of service. We accept: cash, check, and credit card (Visa, MC, and Discover).

2. All deductibles MUST be collected after filing with your insurance. (All deductibles will be collected at the time of service if we are not a participating provider with your insurance company).

3. Failure to pay the designated co-pay amount set by your insurance company will result in an additional charge. We will be enforcing a non-payment of co-pay fee. This fee will be an additional charge added to your total for those charges accrued for treatment. This fee does not waive your co-payment.

4. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you sign the benefits to Dr. Claire Visitacion (in other words, have your insurance company pay the doctor directly). If your insurance company does not pay the practice within reasonable period, we must look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.

5. If you owe us money due to insurance, we have a Loan Agreement and Promissory Note that will allow you to pay Health Associates of Georgia, Inc. off.

6. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits if we are your primary care physician (PCP). We will bill them and you are required to pay a co-payment at the time of your visit, per insurance policy.

7. If you are insured by a plan that we do not have prior arrangement with, we will prepare and send the claim for you on an assigned basis. This means the insurer will send the payment directly to you. Therefore, our charges for your care are due at the time of service.

8. Not all insurance plans cover all services. For example, Medicare does not cover certain services. If your insurance plan determines a service to be “not covered”, you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

9. We will bill your insurance company for all services provided by or on behalf of Health Associates of Georgia, Inc. at Bethlehem Family Healthcare. You are responsible for any balance due.

10. Bethlehem Family Healthcare sends all labs to an outside laboratory (Solstas, Lab Corp, Quest). Since we are not affiliated with these laboratories, all questions regarding your bill will need to be directed to that laboratory. We ask that you call the number listed on your bill as we will not be able to entertain any calls regarding this matter.

9. If you fail to cancel an appointment within 24 hours or not show up for an appointment, Bethlehem Family Healthcare will charge **$45** which is <u>not</u> covered by your insurance company.

10. If a check is returned due to insufficient funds, all future payment must be made in cash and there will be a charge of **$35.00**.

Bethlehem Family Healthcare does not participate in legal issues, i.e. divorce, accidents or other legal issues, and all payments are expected in full at the time of service from the guardian or approved person bringing the patient to Bethlehem Family Healthcare.

<u>Fees are as follows:</u>

Non-Payment of Co-Pay: $10.00
Returned Check Fee: $45.00 (your method of payment will then be cash/credit only)
No Show Appointment Fee:

1st Offense- Warning Letter
2nd Offense- $45.00 (must be paid prior to being seen again)
3rd Offense- Possible Dismissal

Year-end detailed receipts for taxes: $3.00 per patient
Completion of Paperwork (FMLA, AFLAC, Disability, Etc.): $25.00
All Copies and paperwork will be completed 10-14 business days from the time a signed request is received.

My signature bellows acknowledges that I have read and agree to all the following. I acknowledge that is it responsibility of the patient and/or guardian to provide and maintain active insurance coverage; otherwise all charges incurred will be my responsibility. This document can, and if necessary, be used in a court of law. A photocopy of this agreement is considered as valid as an original. I hereby assign all medical benefits, to include medical major benefits to which the patient is entitled, private insurance and any other health plans to **<u>Health Associates of Georgia dba. Bethlehem Family Healthcare</u>**. I hereby authorize assignee to release all information necessary to secure payment.

Patient/Guardian Name: _____ Date: _____

Patient/Guardian Signature: _____

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED, DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND SIGN.

This notice is required by law to tell you how Bethlehem Family Healthcare protects the confidentially of your health care information in our possession. Protected Health Information (PHI) is defined as any individually identifiable information regarding a patient's healthcare history, mental or physical condition, and treatment. Some examples of PHI include your name, address, telephone and/or fax number, electronic mail address, social security number or any other identification numbers, date of birth, dates of treatment, treatment records, x-rays, enrollment and claim records. Bethlehem Family Healthcare uses and disclosed your PHI to administer your benefit plan or as permitted or required by law. Any other disclosure of your PHI without your consent in writing is prohibited.

We must follow these privacy practices as well as any other federal or state laws which apply to your PHI. Anew privacy statement will be given to you should any changes be made to this notice. You may request a copy of the notice at any time by contacting us at the address and phone number listed above.

We are permitted to use or disclose your health information without prior authorization for the following purposes; insurance companies for the purpose of healthcare treatment and payment of claims, professional affiliates to whom we may refer you to for further treatment. We may disclose your information to third parties that perform services for Bethlehem Family Healthcare in the administration of your benefits. These parties have signed a contract agreeing to protect the confidentiality of your information.

We are also permitted to use and/or disclose your PHI to comply with a valid authorization, to notify family members, any other person or a personal representative of your condition, to assist in a disaster relief efforts and to report victim abuse, neglect or domestic violence. Other permitted disclosures are for the purpose of health oversight by government agencies, judicial, administrative or other law enforcement purposes. Information about decedents to coroners, medical examiners and funeral directors for research purposes, organ donation purposes, to avert a serious threat to health or safety for specialized government functions such as military and veteran activities, for worker's compensation purposes and for use in creating summary information that can no longer be traced to you. We use administrative, technical and physical safeguards to maintain the privacy of your health information. We may release your health care

information to other insurers for the purpose of claims payment. We also use your health care information to review your quality of care or to resolve any grievance you may have.

DISCLOSURES WITHOUT AN AUTHORIZATION:

We are required to disclose your PHI to the U.S. Secretary of Health and Human Services to investigate or determine the compliance with law. Bethlehem Family Healthcare may disclose your health information without prior authorization to: law enforcement with a court order, subpoena, search warrant or coroner during an investigation.

You have the right to request a copy of your PHI by contacting Bethlehem Family Healthcare. Please include your name, address, telephone number, date of birth, and social security number. Bethlehem Family Healthcare may charge a reasonable fee providing you with copies of the information. Bethlehem Family Healthcare can only provide you information that has been generated in their office. We cannot give you copies of records from another provider. You have the right to request a restriction of your health information; however, we will put limits on what information can be restricted. There is some information that we are legally bound to disclose. You have the right to request confidential communication from us by alternative means or at a different address if you could be in danger. You will be required to provide us with a statement of the possible danger if information is sent to you at your current address.

You understand that we are providing health care to you and this practice will send any medical records required by a specialist, hospital, lab, pharmacy or insurance company in order to benefit your health care. We appreciate the opportunity to provide your health care.

Thanks,
Bethlehem Family Healthcare

Patient/Guardian Name: _____ Date: _____

Patient/Guardian Signature: _____

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Hospital/Laboratory Preference Form

Patient Name: _____

Date of Birth: _____

Since it is your responsibility to be aware of which hospital and/or laboratory your insurance company covers, please indicate those choices below:

Hospital(s): _____

Laboratory: _____

In the event the information changes, it is your responsibility to notify a member of the staff of the changes in writing.

Signature of patient or guardian: _____

Print Name: _____ Date: _____