Medicas
Medical Clinic LLC

Registration Form

I. PATIENT INFORMATION

Today's Date:

Last Name: **First Name:** **MI:** **DOB:** / /

Address: **City:** **State:** **Zip:**

Sex: Male Female **Marital Status:** Single Married Widowed Divorced **Ethnicity:** Hispanic/Latin Not Hispanic/Latin

Race: African American/Black Hispanic Caucasian/White Native American Other:

Social Security Number (SSN): - - **Occupation:**

Home #: ( ) **Cell#:** ( ) **Work #:** ( )

May We Contact You On These Numbers? Yes No Consent To Text? Yes No

Emergency Contact: **Relationship:** **Contact #:** ( )

E-Mail Address:

Pharmacy: **Address:** **Phone:** ( )

II. RESPONISIBLE PARTY *if patient is a minor (under 18), fill in parent/guardian information below.*

Last Name: **First Name:** **MI:** **DOB:** / /

Address: **City:** **State:** **Zip:**

SSN: - - **Phone:** ( ) **Relationship to patient:**

E-Mail Address:

III. INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDAY INSURANCE
Ins. Co. Name:	**Ins. Co. Name**:
Policy/Member ID #:	**Policy/Member ID #:**
Policy Holder Name:	**Policy Holder Name:**
Policy Holder DOB: / /	**Policy Holder DOB:** / /
Patient Relationship to Policy Holder:	**Patient Relationship to Policy Holder:**

Our office policy is to collect payment at the time of service rendered. All co-pays, deductible and co-insurance amounts should be paid to the receptionist at check-in.

I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to MMC all money to which I am entitled for medical expenses related to the services performed from time to time by MMC, but not to exceed my indebtedness to MMC. I authorize MMC to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. I choose to receive communications from MMC by text or e-mail at the number or address stated above, including but not limited to communications about appointments, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to MMC. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

I assign to Medicas Medical Clinic, LLC (MMC) all payments for medical services. I understand that I am responsible for any amount not covered by my insurance. I authorize MMC to furnish information to insurance carriers, physicians or hospitals concerning my illness and treatments. I authorize any physician, hospital or care facility to provide all information on medical history and treatment to MMC and I authorize photo copies of this form to me as valid as the original in the event that my records that my records need to be faxed for any reason and/ or accidentally misdirected. I release MMC for any liability. I have read and understood the above and give MMC to treat me.

Patient signature or authorized signature :_____ **Date**:_____

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IV. PATIENT FINACIAL POLICY

Welcome to Medicas Medical Clinic, LLC

We are pleased that you have chosen us to be your provider of primary care and we are committed to providing you with quality and affordable healthcare. The following information outlines your financial responsibilities as it relates to payment for services you are to receive.

Insurance – We participate in most insurance plans, including Medicare. If you have a secondary insurance or supplemental policy we will send claims to both. If you are not insured by a plan that we do business with, payment in full is expected at each visit. If you are insured by a plan that we do business with but do not have an up-to-date insurance card on file, payment in full 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.

Proof of Insurance – All patients must complete our patient information form before seeing the physician. We must obtain a copy of your driver's license and a 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 charges incurred.

Coverage Changes – If your insurance changes, please notify us before your next visit so we can update your records to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days; the balance can be billed to you.

Co-payments and deductibles – All co-payments and deductibles must be paid at the time of service. This arrangement is in compliance with your contract with your insurance company. For your convenience we accept cash, and credit cards. We do not accept checks for payment.

Waiver of patient responsibility – It is the policy of Medicas Medical Clinic to treat all patients in an equitable fashion related to account unbalances. The practice will not waive, fail to collect, or discount copayments, co-insurance, deductibles, or other patient financial responsibility in accordance with state and federal law, as well as participating agreement with payers.

Non-covered Services – Please be aware that some services you receive may be non-covered or not considered reasonable or necessary by your insurer. You must pay for these services in full prior to or at the time of visit.

Patient signature or authorized signature :_____ **Date**:_____

Continue to next page

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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 to them. It is your responsibility to comply with their request in a timely manner. 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 a party to that contract.**

Nonpayment – If your account is over 90 days past due, we may refer your account to a collection agency. In the event an account is turned over for collections, the person financially responsible for the account will be responsible for collection costs including attorney fees and court costs. Additional appointments may not be scheduled until your account is returned to good standing. Partial payments will not be accepted unless otherwise negotiated.

For Our Patients with no Medical Insurance – If you do not have group or individual medical insurance, payment for all professional services is expected at the time of your visit. Please note, we do offer discounted fees for patients without health insurance. In order to receive the discount, payment must be made in full at the time of service.

Managed Care Patients/Referrals and Authorizations – I understand that I am required to obtain proper referral and/or authorization as required by my insurance plan prior to my appointment with any of the Medicas Medical Clinic Physicians. If authorization is not obtained for my visit my insurance may not pay for my treatment. If this is the case I will be responsible for any charges incurred. I understand that Medicas Medical Clinic is not obligated to see a patient without a valid referral authorization. If my insurance plan sends me a check for payment of the medical services provided by Medicas Medical Clinic, the check belongs to Medicas Medical Clinic and I must immediately deliver the check to Medicas Medical Clinic for payment on my account. In the event that my insurance plan denies my claim and I choose to appeal their decision, this form and my signature authorizes my Physician to submit an appeal along with any necessary medical information to my insurance plan.

Our practice is committed to providing the best treatment to our patients. Thank you for your understanding of our financial policy and please let us know if you have any questions or concerns.

I have read and understand the patient financial policy and agree to abide by its guidelines:

Patient signature or authorized signature :_____ **Date**:_____

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V. CONSENT AND RELEASE

USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I, _____ understand that as part of my healthcare MMC, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and procedure information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry our treatment, payment or health care operations.

I understand that MMC is not required to agree to the restrictions requested.

I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance there on.

I also understand that by refusing to sign this consent or by revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations. I further understand that MMC, reserves the right to change their notice and practice and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations.

Should MMC change their notice, they will send a copy of any revised notice to the address I've provided. I wish to have the following restrictions to the use or disclosure of my health information: I understand that as part of this organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and

I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent.

Patient signature:_____ **Date**:_____

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VI. PAIN AND NARCOTICS POLICY

Medicas Medical Clinic, LLC (MMC) is a *Primary Care/Family Practice* and ***we prescribe narcotic medication very carefully***.

That is because abuse of prescription narcotics has exploded into a national epidemic. Accidental death from overdose of prescription narcotics now exceeds that of heroin and cocaine combined. According to healthcare guidelines, pain and narcotic medications should be controlled and prescribed by a *specialist* based on patient needs. One of the highest privileges and responsibilities given to a medical provider is relief from symptoms that our patients go through. Some patients have a need for medicine on a long term and daily basis.

For our patients' safety, MMC physicians and advanced practitioners evaluate each patient's situation and develop a management plan that considers all available relief options, including physical therapy, chiropractic care, non-narcotic pain medication, or behavioral healthcare.

Patients who are prescribed narcotics or in need of these medications must sign an agreement, which explains the responsibilities of both the physician and the patient. In addition, we require a random urine drug testing for other drugs (including illegal or unauthorized prescription drugs) that may cause dangerous interactions. This helps to ensure that patients are safe and that we are in compliance with the state's and Medicas Medical Clinic strict prescribing guidelines.

New patients to MMC who report chronic pain or have been prescribed narcotic medication in the past by other doctors will be carefully evaluated by their new MMC physicians, to determine the best course of treatment. Therefore, we ask new patients to understand that previous use of narcotic pain medication does not mean that these medications will automatically be prescribed or renewed by the MMC prescribers. MMC providers may also require medical records for proof of existing medication use. All MMC providers follow the same safe narcotic prescribing procedures. Patients evaluated and felt to be at risk for withdrawal from chronic narcotic use, may be counseled to seek care at a drug detox center.

Narcotics like: Percocet, Lorcet or Lortab 7.5 mg or 10 mg, Morphine, Demerol, Fentanyl, Oxycodone, Methadone, Ativan or Xanax and others are examples of medication that would have to go thought MMC Protocol.

At MMC, our goal is always to provide patients with the safest and most appropriate care. We ask for our patient's assistance in ensuring the proper use of narcotic medication.

We are required by Georgia State Law to forward any suspicious requests, sales, or criminal activity to the DEA. We enthusiastically endorse this action and are compliant with this law.

Signing below states you read and understand this policy.

Patient signature:_____ **Date**:_____

Witness signature: _____ **Date**:_____

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VII. Health History Form

Name: **DOB:** / /

Reason for visit:

Care Team/Specialist

Specialty:_____ MD:_____ Phone:_____
Specialty:_____ MD:_____ Phone:_____
Specialty:_____ MD:_____ Phone:_____

Medications *please include all over-the-counter medications, vitamins, herbals and supplements*

□ Check here if NONE

Name:_____ Dosage(ml, g, mg, mcg): _____ Times per day:_____
Name:_____ Dosage(ml, g, mg, mcg): _____ Times per day:_____
Name:_____ Dosage(ml, g, mg, mcg): _____ Times per day:_____
Name:_____ Dosage(ml, g, mg, mcg): _____ Times per day:_____
Name:_____ Dosage(ml, g, mg, mcg):_____ Times per day:_____
Name:_____ Dosage(ml, g, mg, mcg): _____ Times per day:_____

Should you require additional space for medication list, please check here ____ and write on the back of this page.

Allergies *(circle)*: None YES (*specifiy):*_____

Family History

	No	Yes	Age	Age of Death	Relationship
Diabetes					
Hypertension					
Thyroid					
Stroke					
Heart Disease					
Cancer; Type					
Arthritis					
Depression					

Surgical History

□ Check here if NONE

Procedure:_____ Date:_____
Procedure:_____ Date:_____
Procedure:_____ Date:_____
Procedure:_____ Date:_____
Procedure:_____ Date:_____

Obstetric and Gynecological History (WOMEN ONLY)

Last Mammogram Date: _____ □ Abnormal
Last PAP Date:_____ □ Abnormal
Age of first menstrual period: _____
Date of last menstrual period:_____
# of Pregnancies: _____
- *Full-term:*_____
- *Premature:*_____
- *Mischarge:*_____
- *Abortion*:_____

Cesarean sections: no yes(#):_____

Check (√) current symptoms

□ Bleeding between periods
□ Heavy periods
□ Extreme menstrual pain
□ Vaginal itching, burning or discharge
□ Wake in the night to go to the bathroom
□ Hot flashes
□ Painful intercourse
□ Breast lump
□ Nipple discharge

MEN ONLY

Check (√) current symptoms

□ Breast Lump
□ Erection difficulties
□ Lump in testicles
□ Penis discharge
□ Sore on penis

Other:_____
_____
_____

Social History *Check (√)*

Education: □ Less than 8th grade □ High School □ 2 year college □4 year college □ Post graduate
Marital status: □ Single □ Married □ Divorced □ Separated □ Widowed □ Domestic partner
Caffeine: □ None □ Occasional □ Moderate □ Heavy # of cups per day? _____
Alcohol: Do you drink alcohol? □ No □ Yes if so, how often? □ Occasional □ < 3 times a day □ > 3 times a day
Exercise Level: □ None □ Occasional □ Moderate □ Heavy
Tobacco: Do you use tobacco? □ No □ Yes If not currently, did you ever use tobacco? □ No □ Yes
Have you ever used: □ Cigarettes _____ pks/day □ Chew ____/day □ Cigars ____/day Years of use:_____
Drugs: Do you currently use recreational or street drugs? □ No □ Yes

Patient or authorized signature: _____ **Date:** _____

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Past Medical Conditions *Check (√) current medical conditions*

- □ Abuse/Domestic Violence
- □ ADD/ADHD
- □ AIDS/HIV
- □ Allergies/ hay fever
- □ Anemia
- □ Anesthesia complications
- □ Anxiety Disorder
- □ Alcoholism
- □ Appendicitis
- □ Arthritis
- □ Asthma
- □ Bed Wetting
- □ Birth defect or Inherited Disease
- □ Bladder or Kidney problems
- □ Bleeding Disorders
- □ Blood Transfusion
- □ Breast Problem
- □ Bronchitis
- Cancer
- □ Cataracts
- □ Chicken Pox
- □ Constipation
- □ COPD
- □ Depression
- □ Diabetes
- □ Ear or hearing problem
- □ Eating Disorders
- □ Eczema
- □ Endometriosis
- □ Fibroids
- □ GI Problems
- □ Gout
- □ Headache/Migraine
- □ Heart Conditions
- □ Hepatitis
- □ Hernia
- □ Herpes
- □ High Cholesterol
- □ Hospitalizations
- □ Hypertension
- □ Infertility
- □ Kidney Disease
- □ Kidney Stones
- □ Liver Stones
- □ Lung Disease
- □ Mental Disorder/illness
- □ Muscle, Joint or Bone Problems
- □ Obesity
- □ Pneumonia
- □ Polyps
- □ Prostate problem
- □ Reflux/GERD
- □ Seizures/epilepsy
- □ Skin problems
- □ Stoke
- □ Thyroid problems
- □ Vision or eye problems

Review of Symptoms *Check (√) if below apply*

Allergic/Immunologic
- □ Frequent Sneezing
- □ Hives
- □ Itching
- □ Runny Nose
- □ Sinus Pressure

Cardiovascular
- □ Arm Pain on Exertion
- □ Chest Pain on Exertion
- □ Chest Heaviness/Pressure on Exertion
- □ Irregular Heart Beats (Palpitations)
- □ Known Heart Murmur
- □ Light-headed on Standing
- □ Shortness of Breath When Lying Down
- □ Shortness of Breath When Walking
- □ Swelling (edema)

Constitutional
- □ Exercise Intolerance
- □ Fatigue
- □ Fever
- □ Weight Gain (_____lbs)
- □ Weight Loss (_____lbs)

Eyes
- □ Dry Eyes
- □ Irritation
- □ Vision Change

Date of Last Exam:_____

Endocrine
- □ Fatigue
- □ Increased
- □ Thirst/Hunger/Urination

Ears/Nose/Mouth/Throat
- □ Bleeding Gums
- □ Difficulty Hearing
- □ Dizziness
- □ Dry Mouth
- □ Ear Pain
- □ Frequent Infections
- □ Frequent Nosebleeds
- □ Hoarseness
- □ Mouth Breathing
- □ Mouth Ulcers
- □ Nose/Sinus Problems
- □ Ringing in Ears

Gastrointestinal
- □ Abdominal Pain
- □ Black or Tarry Stool
- □ Blood in Stool
- □ Change in Appetite
- □ Frequent Indigestion
- □ Hemorrhoids
- □ Trouble Swallowing
- □ Vomiting
- □ Vomiting Blood

Genitourinary
- □ Blood in Urine
- □ Difficulty Urinating
- □ Incomplete Emptying
- □ Increased Urinary Frequency
- □ Urinary Loss of Control

Hematologic/Lymphatic
- □ Easy Bruising/Bleeding
- □ Swollen Glands

Integumentary (Skin)
- □ Dry Skin
- □ Eczema
- □ Growth/Lesions
- □ Itching
- □ Jaundice (Yellow Skin/Eyes)
- □ Rash

Musculoskeletal
- □ Back Pain
- □ Joint Pain
- □ Muscle Aches
- □ Muscle Weakness

Neurological
- □ Dizziness
- □ Fainting
- □ Headaches
- □ Memory Loss
- □ Migraines
- □ Numbness
- □ Restless Legs
- □ Seizures
- □ Weakness

Psychiatric
- □ Alcohol Overuse
- □ Anxiety/Stress
- □ Depression
- □ Do Not Feel Safe in Relationship
- □ Mania
- □ Sleep Problems

Respiratory
- □ Cough
- □ Shortness of Breath
- □ Sleep Apnea
- □ Snoring
- □ Wheezing

Patient or authorized signature: _____ Date: _____