Sutter Family Practice, Inc.
320 West Market Street
Chatsworth, GA 30705
(706) 695-0466

Patient Demographics

PATIENT INFORMATION

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Date of Birth: _____/_____/_____ **Social Security Number:** _____- _____-_____ **Gender:** Male or Female

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed **Primary Language:** _____

Race: □ American Indian □ Black □ Hispanic □ White □ Other: _____

Home Address: _____ **Apt #:** _____

City: _____ **State:** _____ **Zip:** _____

Mailing address (if different from home address): _____ **Apt#:** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone #: (_____) _____-_____ **Work Phone:** (_____) _____-_____ **Cell Phone:** (_____) _____-_____

Email Address: _____

Employment status: □ Employed □ Unemployed □ Retired □ Student □ Disabled □ Active Military □ Retired Military

Employer: _____ **Employer Phone:** (_____) _____-_____

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient: _____

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Date of Birth: _____/_____/_____ **Social Security Number:** _____- _____-_____

Home Address: _____ **Apt #:** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone #: (_____) _____-_____ **Work Phone:** (_____) _____-_____ **Cell Phone:** (_____) _____-_____

Email Address: _____

Employment status: □ Employed □ Unemployed □ Retired □ Student □ Active Military □ Retired Military

Employer: _____ **Employer Phone:** (_____) _____-_____

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Last Name: _____ **First Name:** _____

Relationship to Patient: _____ **Home Phone #:** (_____) _____-_____ **Cell Phone:** (_____) _____-_____

NOT LIVING WITH PATIENT:

Last Name: _____ **First Name:** _____

Relationship to Patient: _____ **Home Phone #:** (_____) _____-_____ **Cell Phone:** (_____) _____-_____

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Patient Insurance

INSURANCE INFORMATION

Please provide your insurance card(s) and your drivers license to the receptionist to be scanned into your patient chart.

Primary Insurance

Insurance Co.: _____ **Insurance Phone: (_____) _____-_____**

Policy Holder: _____ **Date of Birth: _____/_____/_____**

ID/Policy #: _____ **Group #:** _____ **Group Name:** _____

Secondary Insurance:

Insurance Co.: _____ **Insurance Phone: (_____) _____-_____**

Policy Holder: _____ **Date of Birth: _____/_____/_____**

ID/Policy #: _____ **Group #:** _____ **Group Name:** _____

Tertiary Insurance:

Insurance Co.: _____ **Insurance Phone: (_____) _____-_____**

Policy Holder: _____ **Date of Birth: _____/_____/_____**

ID/Policy #: _____ **Group #:** _____ **Group Name:** _____

To the best of my knowledge, the above information is true and complete. I understand that I am responsible to pay for all services rendered to me, and that I am willing to make specific arrangements to pay whatever part is not covered by insurance on a timely basis.

I grant permission to my physician to mutually exchange information with my referring physician(s) and/or their associates. Also, to the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's medical record to my insurance carrier or medigap carrier.

If this account is assigned to an attorney for collections and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection. I hereby assign all medical benefits to which I am entitled to my physician for services rendered to my dependent or me. This assignment will remain in effect until revoked, by me, in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient Signature: _____ **Date**: _____

Sutter Family Practice, Inc.
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Medical History

PATIENT INFORMATION

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Date of Birth: _____/_____/_____ **Social Security Number:** _____- _____-_____ **Gender:** Male or Female

CURRENT MEDICATIONS

Name of Medication:	Dosage:	Frequency:	Purpose:

Please attach additional sheet if needed

MEDICATION ALLERGIES

Are you allergic to any Medications? □ **YES** □ **NO** **If yes, please list:**

Name of Medication:	Reaction:

SURGICAL HISTORY

Have you ever had any surgical procedures? □ **YES** □ **NO** **If yes, please list:**

Surgical Procedure Performed:	Date:

HOSPITALIZATIONS

Have you stayed overnight in the hospital within the last 10 years? □ **YES** □ **NO** **If yes, please list:**

Reason for Hospital Stay:	Date:

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Medical History Continued

MEDICAL HISTORY

Do you now or have you ever had any of the following:

□ Anemia
□ Cataracts
□ Diabetes
□ Goiter
□ High blood pressure
□ Hypothyroidism
□ Kidney stones
□ Psoriasis
□ Stomach ulcer
□ Asthma
□ Crohn's disease
□ Emphysema
□ Heart problems
□ High cholesterol
□ Jaundice
□ Pain (type): _____
□ Pulmonary embolism
□ Stroke
□ Cancer (type): _____
□ Colitis
□ Epilepsy (seizures)
□ Hepatitis
□ HIV / AIDS
□ Kidney disease
□ Pneumonia
□ Rheumatic fever
□ Tuberculosis

Have you ever had trauma injuries caused from an accident (car wreck, sports injury, etc.)? □ YES □ NO
If yes, please explain:
_____
_____
_____

Have you ever been diagnosed or treated for any mental illness? □ YES □ NO If yes, please explain:
_____
_____
_____

Do you Smoke? □ YES □ NO If yes, how many packs per day? _____

Have you smoked in the past? □ YES □ NO If yes, when did you quit smoking? _____

Do you drink alcohol? □ YES □ NO If yes, how much per week? _____

Do you use illegal drugs? □ YES □ NO If yes, please list illegal drugs used? _____

Have you had any substance abuse? □ YES □ NO If yes, please explain including substances abused:
_____
_____
_____

FAMILY MEDICAL HISTORY

Please indicate family members who have had any of the following conditions:
(Father, Mother, Sister, Brother, Grandmother, Grandfather)

Medical Condition:	Relative:	Medical Condition:	Relative:
Alcoholism		Genetic diseases	
Alzheimer's Disease		Glaucoma	
Anemia		Heart disease	
Anesthesia problem		Heart problems	
Arthritis		High Blood Pressure	
Asthma		High Cholesterol	
Birth defects		Kidney diseases	
Bleeding problem		Migraine headaches	
Breast cancer		Mitral Valve Prolapse	
Colon cancer		Osteoarthritis	
Ovarian cancer		Osteoporosis	
Prostate cancer		Rheumatoid arthritis	
Melanoma cancer		Stroke	
Depression		Thyroid disorders	
Developmental disability		Tuberculosis	
Diabetes			

Sutter Family Practice: Patient Financial Policy

Effective 01/01/2020

Purpose:
Sutter Family Practice is committed to building a successful physician-patient relationship with patients and their families. The last several years have been a time of profound change regarding health care reform, so much that it has become necessary to implement the Patient Financial Policy. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is part of that relationship.

1. We will collect patient's deductible, co-pay, uncovered services or the percent patient is responsible for at the time of their visit. Patients should be prepared to pay at the time of check-in, before they are seen by a provider. It is the patient's responsibility to know the terms of their insurance plan.
2. Patient must bring insurance card(s) and photo I.D. to all appointments and any authorization information they may have. Without these, we are unable to see the patient.
3. We will file patient insurance if we are providers for their plan. It is the patient's responsibility to make sure we received prompt payment from them.
4. If the patient's insurance company denies payment on their claim, patient will be responsible for any and all charges not paid.
5. In accordance with AMA CPT guidelines, we reserve the right to charge for telephone calls with our medical professionals that include evaluation and management of your medical condition.
6. Patients requiring a referral are responsible for making sure visits with Sutter Family Practice are authorized by their insurance. This authorization must be obtained before the scheduled visit. It is the patient's responsibility to make sure Sutter Family Practice has received authorization. If patients do not have proper authorization, the appointment will be re-scheduled, and patient may be subject to a $50 charge for a missed office visit.
7. Self-Pay Patients includes patients with no insurance and the patients who have an insurance plan with which we do not participate. Payment for medical services is required prior to services being rendered. We accept Visa, MasterCard, Discover and American Express, checks, cash and money orders. Patient will be provided with a receipt of payment.
8. Should a patient need to cancel or change their office visit appointment, the patient will be subject to a $50 charge if patient does not do so with 24 hours business day advanced notice.
9. Sutter Family Practice does not file urine drug screens to any insurance plan. This charge is the patient responsibility and must be paid before being seen by a provider.
10. A patient account will be turned over to collections when a payment has not been made on the account within the last 60 days regardless of account balance. An attempt will be made to contact the patient by phone and by mail before any account is turned over to collections.
11. In the event a patient account is turned over to collections, a 30% fee will be added to the patient account balance at the time the account is turned over to collections.
12. A returned check fee of $35 will be applied to a patient account for any returned checks due to insufficient funds.

Final Note: Remember, you and/or your employer pay the monthly insurance premiums. Your insurance company is accountable to you. Do not hesitate to contact them if you disagree with the status of your claim(s).

If you have any questions regarding this Patient Financial Policy, please ask or call BEFORE you are seen by a provider.

By signing below, I agree to all terms of the Sutter Family Practice Patient Financial Policy.

Patient Name: _____ **DOB: _____**
(please print)

Signature: _____ **Date: _____**
(patient or legal guardian)

Sutter Family Practice: Patient Attendance and Dismissal Policy

Effective 01/01/2020

Purpose:
To establish a standardized process for the dismissal of patients from a provider's practice that enhances access and care provision to all patients.

Definitions:
No Show – patient does not show for a scheduled appointment, arrive 15 minutes after the scheduled start time or fails to cancel within 24 hours of the scheduled visit.
Cancellation – patient cancels any time prior to 24 hours before their scheduled appointment
Patient Reschedule – patient must reschedule their appointment more than 24 hours in advance of the original
Clinic Reschedule – patient appointment must be rescheduled by Sutter Family Practice

Policy:

I. Sutter Family Practice's manager or their designee will monitor "no shows" and cancellations via monthly reports. The specific patient data will be shared with the patient's provider as necessary and a joint decision will be made regarding dismissal for excessive no shows and/or cancellations as outlined below. Sutter Family Practice strives to provide compassionate and excellent care for all patients, but in the event that a patient cannot comply, the following policy will be enforced.
   i. Persistent or broad failure to adhere to medical advice and treatment
   ii. Seeking controlled substances without clinical justification or providing false or knowingly withholding information regarding controlled substances.
   iii. Acting in a threatening, disruptive and/or inappropriate manner toward provider, staff or others, either in the office or on the phone.
   iv. Excessive no shows (more than three in a rolling 12-month period) and cancellations (more than five in a rolling 12-month period).
   v. Failure to attend the first scheduled "New Patient" appointment will result in immediate dismissal from Sutter Family Practice.
   vi. Failure to pay any account balance in full in a timely manner.
   vii. Any other reason that the provider feels prevents them from maintaining a therapeutic relationship with the patient which includes provider-patient trust.

Procedures:

No Shows-

I. All no shows, cancellations and reschedules will be recorded in the billing alert located in eCW. The clinic staff recording the no show, cancellation or reschedule will time stamp and record patient's reason and the person giving the information. Clinic staff will also create a telephone encounter and send to Practice Manager.
II. After the third no show and with provider approval, a dismissal letter will be sent by certified mail on behalf of the clinic.
III. The dismissal letter will contain, at minimum, the following components:
   i. Reason for discharge.
   ii. Information regarding account balance due, if applicable.
IV. A copy of the letter will be scanned into the patient's chart, along with certified receipt. In the event the patient's registered letter is returned to the clinic, the original will be scanned into the chart. The patient will be charged a $10 fee for any certified mail that is returned.
V. When a patient is dismissed from the practice an alert will be entered into the patient's chart next to the patient's name and in the billing alert.
   Example: (Doe, John R. *DISMISSED)
VI. Care will not be re-established once a patient has been dismissed from the practice.

Unpaid Account Balances-

I. Patient will be contacted via phone three times to notify them of the balance on the account. If patient is unreachable by phone, a letter will be mailed to notify patient of account balance.
II. Patient will be turned over to collections after above mentioned efforts have been exhausted without success. A letter will be sent via certified mail to the patient to notify account debt has been turned over to the collection agency of our choosing and information regarding patient dismissal from the practice.
III. The dismissal letter will contain, at minimum, the following components:
   i. Reason for discharge.
   ii. Information regarding account balance due.

IV. A copy of the letter will be scanned into the patient's chart, along with certified receipt. In the event the patient's registered letter is returned to the clinic, the original will be scanned into the chart. The patient will be charged a $10 fee for any certified mail that is returned by mail.

V. When a patient is dismissed from the practice an alert will be entered into the patient's chart next to the patient's name and in the billing alert.
Example: (Doe, John R. *DISMISSED)

VI. Care will not be re-established once a patient has been dismissed from the practice.

MESSAGE TO PATIENTS:

You, the patient, are the leader of your healthcare team. Regularly attending all your appointments at Sutter Family Practice and elsewhere is essential to the success of our multi-disciplinary treatment team. Sutter Family Practice cannot effectively treat you if your attendance is erratic. Certain medications require you to have regular visits and health problems respond best to treatment approaches that require your careful cooperation and attendance. We urge you to take your scheduled appointments very seriously, as we do. If you miss an appointment, it may be several days before we can fit you into the schedule.

If you miss an appointment and are needing medication(s) refilled, please note it is at the provider's discretion as to what medications are refilled, if any, and how much is prescribed.

Please notify our office at least one business day in advance of any appointment you are unable to keep by calling (706) 695-0466. Cancelling your appointment less than one business day in advance will be considered a "no show," and more than three no shows in a rolling 12-month period could lead to dismissal from the practice.

Reserved appointments are provided to minimize waiting and ensure continuity of your care. Our policy is strict, but also designed to be flexible in case of emergencies. We are committed to providing you with a high-quality care and ask that you please let us know how we can help you maintain an active role in your health.

All efforts will be made to collect any debt owed to Sutter Family Practice. Please make necessary arrangements to keep your account current.

Patient Name: _____ **DOB: _____**
(please print)

Signature: _____ **Date: _____**
(patient or legal guardian)

Sutter Family Practice: HIPAA Compliance Patient Consent Form

Effective 01/01/2020

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? □ Yes □ No

May we leave a message on your answering machine at home or on your cell phone? □ Yes □ No

May we discuss your medical condition with any member of your family? □ Yes □ No

If YES, please name the members allowed:

Name: _____ **Relationship: _____**

Name: _____ **Relationship: _____**

Name: _____ **Relationship: _____**

Patient Name: _____ **DOB: _____**

(please print)

Signature: _____ **Date: _____**

(patient or legal guardian)

Sutter Family Practice: Privacy Practices Policy

Effective 01/01/2020

Purpose:
The appropriate collection, use and disclosure of patients' personal health information is fundamental to our day-to-day operations and to patient care. Protecting the privacy and the confidentiality of patient personal information is important to the physicians and staff at Sutter Family Practice. We strive to provide our patients with excellent medical care and service. Every member of Sutter Family Practice must abide by our commitment to privacy in the handling of personal information.

Applicability of This Privacy Policy
Our Privacy Policy attests to our commitment to privacy and demonstrates the ways we ensure that patient privacy is protected. Our Privacy Policy applies to the personal health information of all our patients that is in our possession and control.

What is Personal Health Information?
Personal health information means identifying information about an individual relating to their physical or mental health (including medical history), the providing of health care to the individual, payments or eligibility for health care, organ and tissue donation and health number.

The 10 Principles of Privacy Our Privacy Policy reflects our compliance with fair information practices, applicable laws and standards of practice.

1. Accountability: We take our commitment to securing patient privacy very seriously. Each physician and employee associated with the Practice is responsible for the personal information under his/her control. Our employees are informed about the importance of privacy and receive information periodically to update them about our Privacy Policy and related issues.

2. Identifying Purposes: Why We Collect Information We ask you for information to establish a relationship and serve your medical needs. We obtain most of our information about you directly from you, or from other health practitioners whom you have seen and authorized to disclose to us. You are entitled to know how we use your information, and this is described in the Privacy Statement posted at The Centre for Family Medicine. We will limit the information we collect to what we need for those purposes, and we will use it only for those purposes. We will obtain your consent if we wish to use your information for any other purpose.

3. Consent: You have the right to determine how your personal health information is used and disclosed. For most health care purposes, your consent is implied as a result of your consent to treatment, however, in all circumstances express consent must be written. Your written Consent will be forwarded to the Privacy Officer who will document the request in patient's medical records and notify appropriate Health care providers and their supporting staff. Patients who have withdrawn consent to disclose PHI must sign and date the Consent to Withdrawal Form. It is understood that the consent directive applies only to the PHI which the patient has already provided, and not to PHI which the patient might provide in the future: PHIPA permits certain collections, uses, and disclosures of the PHI, despite the consent directive; healthcare providers may override the consent directive in certain circumstances, such as emergencies; and the consent directive may result in delays in receiving health care, reduced quality of care due to healthcare provider's lacking complete information about the patient, and healthcare provider's refusal to offer non-emergency care. Your written Consent to Withdrawal Form will be forwarded to the Privacy Officer who will document the request in patient's medical records and notify appropriate Health care providers and their supporting staff.

4. Limiting Collection: We collect information by fair and lawful means and collect only that information which may be necessary for purposes related to the provision of your medical care.

5. Limiting Use, Disclosure and Retention: The information we request from you is used for the purposes defined. We will seek your consent before using the information for purposes beyond the scope of the posted Privacy Statement. Under no circumstances do we sell patient lists or other personal information to third parties. There are some types of disclosure of your personal health information that may occur as part of this Practice fulfilling its routine obligations and/or practice management. This includes consultants and suppliers to the Practice, on the understanding that they abide by our Privacy Policy, and only to the extent necessary to allow them to provide business services or support to this Practice. We will retain your information only for the time it is required for the purposes we describe and once your personal information is no longer required, it will be destroyed. However, due

to our on-going exposure to potential claims, some information is kept for a longer period. Patients may be required to sign and date a Consent to Disclose PHI Form and pay a fee based on current OMA rates prior to release of information.

6. Accuracy: We endeavor to ensure that all decisions involving your personal information are based upon accurate and timely information. While we will do our best to base our decisions on accurate information, we rely on you to disclose all material information and to inform us of any relevant changes.

7. Safeguards: Protecting Your Information We protect your information with appropriate safeguards and security measures. The Practice maintains personal information in a combination of paper and electronic files. Recent paper records concerning individuals' personal information are stored in files kept onsite at our office. Access to personal information will be authorized only for the physicians and employees associated with the Practice, and other agents who require access in the performance of their duties, and to those otherwise authorized by law. We provide information to health care providers acting on your behalf, on the understanding that they are also bound by law and ethics to safeguard your privacy. Other organizations and agents must agree to abide by our Privacy Policy and may be asked to sign contracts to that effect. We will give them only the information necessary to perform the services for which they are engaged, and will require that they not store, use or disclose the information for purposes other than to carry out those services. Our computer systems are password-secured and constructed in such a way that only authorized individuals can access secure systems and databases. If you send us an e-mail message that includes personal information, such as your name included in the "address", we will use that information to respond to your inquiry. Please remember that e-mail is not necessarily secure against interception. If your communication is very sensitive, you should not send it electronically unless the e-mail is encrypted, or your browser indicates that the access is secure.

8. Openness: Keeping You Informed. The Practice has prepared this plain-language Privacy Policy to keep you informed. You may view a copy by visiting our website at www.sutterfamilypractice.com. If you have any additional questions or concerns about privacy, we invite you to contact us by phone and we will address your concerns to the best of our ability.

9. Access and Correction: With limited exceptions, we will give you access to the information we retain about you within a reasonable time, upon presentation of a written request and satisfactory identification. We may charge you a fee for this service and if so, we will give you notice in advance of processing your request. If you find errors of fact in your personal health information, please notify us as soon as possible and we will make the appropriate corrections. We are not required to correct information relating to clinical observations or opinions made in good faith. You have a right to append a short statement of disagreement to your record if we refuse to make a requested change. If we deny your request for access to your personal information, we will advise you in writing of the reason for the refusal and you may then challenge our decision.

10. Challenging Compliance: We encourage you to contact us with any questions or concerns you might have about your privacy or our Privacy Policy. We will investigate and respond to your concerns about any aspect of our handling of your information. In most cases, an issue resolved simply by telling us about it and discussing it.

If you have any questions regarding this Privacy Policy, please ask or call BEFORE you are seen by a provider.

By signing below, I have read and understand that Sutter Family Practice works very hard to protect the patient's privacy and preserve the confidentiality of the patient's health information. I also understand that Sutter Family Practice may use and disclose necessary patient health information to help provide care to the patient, handle billing and payment and other necessary health care operations.

Patient Name: _____ **DOB: _____**
(please print)

Signature: _____ **Date: _____**
(patient or legal guardian)

Sutter Family Practice: <u>Authorization to Release Healthcare Information</u>

Patient's Name: _____ DOB: _____/_____/_____
Last First MI.

Maiden Name: _____ SSN#: _____-_____-_____

I request and authorize Doctor/Physician's Office:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

to release healthcare information of the above-named patient to:

Sutter Family Practice
320 West Market Street
Chatsworth, GA 30705
Phone: (706) 695-0466
Fax: (706) 695-0741

<u>Information to be disclosed</u>: I authorize the release of the following health information: (check the applicable box below)

☐ All health care information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.

☐ Only the following records or types of health information: _____
_____
_____

☐ Other: _____
_____
_____

<u>Redisclosure</u>: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Patient Name: _____ **DOB: _____**
(please print)

Signature: _____ **Date: _____**
(patient or legal guardian)