St. Joseph's/Candler Medical Group

Patient Registration

PATIENT DEMOGRAPHICS

Last Name	First Name	M	Nickname

Address	City	State	Zip Code

Home Phone	Cell Phone	Work Phone	Birthdate (MM/DD/YYYY)	Gender
				☐ Male ☐ Female ☐ Transgender

Practice communication preference for Appts, Rx Notices, Test Results: ☐ Phone ☐ Text (SMS) ☐ Both	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Social Security Number

Employer Name	Occupation/Job Title	☐ Full-time ☐ Part-time

Employer Address	City	State	Zip Code

GUARANTOR INFORMATION (only if different from patient)

Last Name	First Name	M	Relationship to Patient

Address	City	State	Zip Code

Home Phone	Cell Phone	Birthdate (MM/DD/YYYY)	Social Security Number

EMERGENCY CONTACT

Relation ☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ Care Giver ☐ Other_____	Last Name	First Name	M

Address	City	State	Zip Code

Home Phone	Cell Phone	Work Phone

PRIMARY INSURANCE INFORMATION

Primary Insurance Company	Policy ID Number #

Coverage Start Date(MM/DD/YYYY)	Subscriber/Insured Name	Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Group Number #	Group Name

SECONDARY INSURANCE INFORMATION

Secondary Insurance Company	Policy ID Number #

Coverage Start Date(MM/DD/YYYY)	Subscriber/Insured Name	Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Group Number #	Group Name

Rx HISTORY CONSENT and ADVANCE DIRECTIVE

Indicate whether you consent for your provider to view your Rx history from external sources.

☐ Yes ☐ No

Advance Directive protects your right to refuse medical treatment that you do not want or to request treatment you do want.

Do you have an Advance Directive? ☐ Yes ☐ No

If NO, would you like more information? ☐ Yes ☐ No

PATIENT PORTAL INFORMATION

Enable Web Portal? ☐ Yes ☐ No

Email Address **(Required for Web Portal)**

ADDITIONAL INFORMATION

Race

☐ Asian ☐ Black

☐ Hispanic ☐ White

☐ Other _____

Ethnicity

☐ Hispanic or Latino

☐ Non-Hispanic or Non-Latino

Language

☐ English ☐ Spanish ☐ Sign (ASL)

☐ Other _____

INSURANCE PREFERRED LAB AND RADIOLOGY SERVICES

If the preferred facility is not designated by the patient, their tests will be sent to St. Joseph's/Candler facilities and the patient will be responsible for payment.

Laboratory

☐ St. Joseph's/Candler ☐ LabCorp ☐ Quest

☐ Other _____

Radiology/X-ray

☐ St. Joseph's/Candler

☐ Other _____

PHARMACY INFORMATION

Pharmacy Name (Primary)	Phone #	Fax #

Address	City	State	Zip Code

AUTHORIZATION TO TREAT

I do hereby consent to and Authorize the performance of all treatments, surgeries and medical services deemed advisable by the health care providers and staff of St. Joseph's/Candler Medical Group to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained hereon are true.

☐ Yes ☐ No Initial _____

ASSIGNMENT OF BENEFITS

I authorize release of information and payment of medical benefits to St. Joseph's/Candler for any services furnished. I understand that I am financially responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage.

☐ Yes ☐ No Initial _____

I have read and understand the above statements and agree to be bound by its terms and conditions. I also understand and agree that such terms may be amended occasionally by the practice.

_____ _____

Patient Signature OR Authorized Representative *Date*

_____

Printed Name of Authorized Representative

St. Joseph's/Candler Medical Group

Patient Medical History

Today's Date: _____

Last Name:_____ First Name:_____ Middle: _____

Chief Complaint

What is the main reason for your visit today? *(Describe your problem in detail)* _____

_____

_____

History of Present Illness

Location of the problem: _____ How long does the problem last? _____

When did you first notice the problem? _____

Is the problem constant or variable? _____ Dull then sharp _____Very sharp then stops _____Constant

Is anything else occurring at the same time? _____Yes _____ No

If yes, please explain. _____

On a scale of 0-10, with 0 being the least painful and 10 being the most painful. Circle number below:

Less pain 0 1 2 3 4 5 6 7 8 9 10 **More pain**

Medical History

- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorder
- ❑ Seizure Disorder
- ❑ Neck/Back Problem
- ❑ Gall Bladder Disease
- ❑ Heart Disease/Heart Attack
- ❑ Stroke/Mini-stroke
- ❑ High Blood Pressure
- ❑ Diabetes
- ❑ Liver Problems
- ❑ Thyroid Disease
- ❑ Lung Problems
- ❑ Migraines
- ❑ Cancer: Organ _____
- ❑ Tuberculosis
- ❑ Reflux/Heart Burn
- ❑ Kidney Problems
- ❑ Irregular Heart Beat

Procedure History

Surgery	Date (Year)	Surgery	Date (Year)
❑ Heart Bypass/Valve Replacement	_____	❑ Stomach Surgery	_____
❑ Hernia Repair	_____	❑ Appendix Removed	_____
❑ Gallbladder Removed	_____	❑ Back/Neck Surgery	_____
❑ Joint Replacement	_____	❑ Prostate Surgery	_____
❑ Bladder/Kidney Surgery	_____	❑ Tonsils Removed	_____
❑ Organ Transplant	_____	❑ Other _____	

St. Joseph's/Candler Medical Group

Patient Family and Social History

List below:

Family Members	Status (Alive, Deceased, Unknown)	Age	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness	Cancer	Unknown	Other
Father										
Mother										
Son(s)										
Daughter(s)										
Brother(s)										
Sister(s)										
Paternal Grandfather										
Paternal Grandmother										
Maternal Grandfather										
Maternal Grandmother										

How many of the following do you have?

Brothers _____ Sisters _____ Sons _____ Daughters _____

Social History

Tobacco Use

❑ **CURRENT SMOKER** Date started? How often? ❑ Every day ❑ Some days

How many? ❑ 5 or less ❑ 6-10 ❑ 11-20 ❑ 21-30 ❑ 31+

How soon after you wake? ❑ Within 5min ❑ 6-30min ❑ 31-60min ❑ after 60min

Interested in quitting? ❑ Ready to quit ❑ Thinking ❑ Not ready

❑ **FORMER SMOKER** Date last smoked? _____

How long since last smoked? ❑ 1-3 months ❑ 3-6 months ❑ 6-12 months ❑ 1-5 years ❑ 5+ years

What type? ❑ Cigarettes ❑ Cigars ❑ Smokeless ❑ Pipe ❑ Other

❑ **NEVER SMOKED**

Alcohol Use

Did you have a drink in the past year? ❑ Yes ❑ No

How often? ❑ Monthly ❑ 2-4 times mth ❑ 2-3 time week ❑ 4 or more a week

How many drinks on a typical day? ❑ 1-2 ❑ 3-4 ❑ 5-6 ❑ 7-9 ❑ 10+

How often you have 6 or more on occasion: ❑ Never ❑ Monthly ❑ Weekly ❑ Daily

Illicit Drug Use

Have you used drugs other than those for medical reasons in the past year? ❑ Yes ❑ No

What type? ❑ Amphetamines ❑ Cocaine ❑ Ecstasy ❑ LSD ❑ Crack ❑ Meth

❑ Prescription Opiates ❑ Heroin ❑ Marijuana ❑ Suboxone ❑ PCP

Route? ❑ Injected ❑ Intranasal ❑ Smoked

Frequency? ❑ Daily ❑ Weekly ❑ Monthly

Are you in treatment? ❑ Yes ❑ No

St. Joseph's/Candler Medical Group

Patient Allergies and Medications

Name of Medication/Substance	What kind of reaction do you have?

Are you taking any medications? ❑ YES ❑ NO

If YES, list all current medications below you are taking and bring prescription bottles to your visit.

Medication Name	Dose	Frequency	Reason for Medication	Prescribing Physician

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Patient Review of Systems

Gastrointestinal	Cardiovascular	Constitutional Symptoms
❑ Abdominal Pain	❑ Chest Pain	❑ Fever
❑ Nausea	❑ Shortness of Breath	❑ Chills
❑ Vomiting	❑ Varicose veins	❑ Sweating
❑ Diarrhea	❑ Palpitations	❑ Weight loss
❑ Constipation	❑ Swelling of extremities	❑ Weakness
❑ Heartburn	❑ Other _____	❑ Other _____
❑ Burping		
❑ Blood in stool		
❑ Other_____		

Skin	Eyes	Musculoskeletal
❑ Skin rash	❑ Blurred Vision	❑ Joint pain
❑ Boils	❑ Double Vision	❑ Back pain
❑ Persistent itch	❑ Other _____	❑ Neck pain
❑ Change in fingernails		❑ Other _____
❑ Hair loss		
❑ Other _____		

Ear / Nose / Throat	Hematologic / Lymphatic	Neurological
❑ Ear pain	❑ Swollen glands	❑ Tremors
❑ Hard of hearing	❑ Easy bruising	❑ Dizzy spells
❑ Sore throat	❑ Other _____	❑ Memory Problems
❑ Runny nose		❑ Frequent Headaches
❑ Other _____		❑ Other _____

Respiratory	Endocrine	Allergic / Immunologic
❑ Wheezing	❑ Excessive thirst	❑ Seasonal allergies
❑ Frequent cough	❑ Fatigue	❑ Sneezing
❑ Sputum	❑ Other _____	❑ Watery/Itchy Eyes
❑ Other _____		❑ Other _____

Female Genitourinary	Male Genitourinary
❑ Frequent urination	❑ Pain in the testicles
❑ Urgent urination	❑ Penile discharge
❑ Pain on urination	❑ Blood in urine
❑ Vaginal discharge	❑ Night time urination
❑ Urine leakage	❑ Frequent urination
❑ Lower abdominal pain	❑ Dribbling of urine
❑ Blood in urine	❑ Difficulty starting urine
❑ Painful menstruation	❑ Other _____
❑ Other _____	

St. Joseph's | Candler
Medical Group

Authorization for Release of Information
Purposes of **HIPAA DISCLOSURE**

I hereby authorize SJC Medical Group to release OR receive the following information from the health records of:
Patient
Name:_____ SSN: _____ DOB: _____

To be released to:

Name	Relationship	Date of Birth	Phone Number

INFORMATION TO BE RELEASED: **(Check All That Apply)**

☐ Entire Record ☐ Lab Results ☐ Nursing Notes ☐ Demographics
☐ Emergency Room Notes ☐ Radiological Results ☐ Physician Orders ☐ Medication Records

FOR THE PURPOSE OF:

☐ Anything on behalf of the patient

☐ Creating/Changing/Canceling appointments

☐ View or correct demographic information to include signing in on my behalf

☐ Receive documents containing my PHI (Protected Health Information) on my behalf with an authorization for release of information signed by me.

☐ Picking up prescriptions/forms and or medications on my behalf.

☐ Speaking to SJC Medical Group staff regarding my PHI including but not limited to billing and insurance information on my behalf.

☐ Other: _____

I understand that I can revoke this authorization by providing written notice to the Health Information Department of St. Joseph's/Candler Medical Group or in a manner described in the Notice of Privacy Rights. I also understand that if the information has been released by relying upon this Authorization, that revocation will not be valid.

I PLACE NO LIMITATIONS ON HISTORY OF ILLNESS OR DIAGNOSTIC AND THERAPEUTIC INFORMATION, INCLUDING ANY TREATMENT FOR ALCOHOL, DRUG ABUSE OR DEPENDENCY, PSYCHIATRIC OR PSYCHOLOGICAL ILLNESS, MENTAL ILLNESS OR RETARDATION AND ACQUIRED IMMUNE DEFICIENCY (AIDS) SYNDROME.

The physician's office listed above may not condition treatment, payment, on the signing of this authorization, unless allowed by law.

I understand that I am waiving my rights to privacy by releasing my medical information to the parties listed above and this information may be re-disclosed by the receiving party. I hereby authorize the entity listed above to release the said information described above.

I understand that this Release of Information will expire within **ONE YEAR** from the date listed below.

_____ _____
Patient Signature *Date*

_____ _____
Patient's Guardian or Capacity *Date*

_____
Relationship to Patient

St. Joseph's/Candler Medical Group

Office and Financial Policies

Appointments and No Show Policy

We believe that our patient's time is valuable and every effort is made to keep your waiting time to a minimum. If you are unable to keep your appointment, please notify the office as soon as possible. This courtesy allows us to give appointments to another patient. If you do not cancel your appointment 24 hours prior to the scheduled appointment time a No Show fee will be charged to your account. If you have 3 or more No Shows within a 12 month period you could be discharged from the practice.

Financial Policy

Due to changes in today's healthcare, your insurance may not always pay for all services. Please make sure you understand your insurance plan and the services that are covered.

- Your Insurance Card(s) and Driver's License (Picture ID) will need to be presented each time you visit our practice to assure we have the most recent information. If insurance card is not provided, appointment will be handled as self-pay and payment for services will be collected prior to being seen.
- Co-payments must be paid prior to seeing the health care provider on the date service is rendered. Patients are responsible for their deductibles or charges not reimbursed by insurance. As a courtesy to you we file your insurance claims, therefore it is your responsibility to provide our office with up to date billing information.
- Please understand that your insurance is a contract between you and your insurance company and you are ultimately responsible for the bill. If you have not received an explanation of benefits within 30 days of seeing your health care provider you are expected to contact your insurance company for an explanation as to why payment has been delayed.
- Self-pay patients are required to pay for services prior to being seen for their visit and will be balance billed for the remainder of the fees at the time of charge posting.
- It is understood that returned checks made payable to this office for insufficient funds, stop payments or other reason for non-payment will be assessed a $30.00 NSF fee for which the patient will be held responsible.
- Patients with no financial ability to pay St. Joseph's/Candler charges will be screened for eligibility under Medicaid and other state programs and/or evaluated against established guidelines for financial assistance. Please notify the Front Desk staff if you would like more information about how to apply for financial assistance.

Patient Portal

The patient portal allows patients to manage their personal health information at their own convenience. You will be able to securely and confidentially exchange non-emergent messages with our practice, request prescription refills, request and keep track of appointments, view referrals to specialists, view lab and imaging results and update your contact information.

Prescription Refills and Samples

You must contact your pharmacy directly for more expedient prescription refills. Please allow your pharmacy up to 48 hours to process your refill request. Please note that prescriptions will not be refilled after hours, on weekends or holidays. Some prescriptions cannot be refilled if you have not seen your health care provider within the last 3-6 months. If you have mail away prescriptions, please allow 7-10 business days for the necessary forms to be completed. It is very important you plan ahead with mail away prescriptions to allow adequate time for paperwork to be processed.

Test Results

Laboratory tests can be performed in our in-house lab, but some special tests may be sent out. You must have an appointment for lab tests and a lab order from your provider. Your health care provider will review your lab/imaging results and notify you via voice message letter or electronically sent to your patient portal. If you have not heard from us within 7 days, please call our office.

REFERRALS

Most insurance plans require a patient to be seen by their primary care provider prior to seeing a specialist. If your insurance plan requires a prior authorization you must verify your insurance has approved the visit before seeing the specialist. Otherwise, you will be responsible for any incurred charges.

Medical Records

Please note that requests for any health information cannot be processed without a signed medical record release from the patient or legal representative. This service is outsourced and processed weekly. Please allow up to 7 business days for your request to be processed. A fee may be charged for this service.

ACKNOWLEDGEMENT OF RECEIPT AND UNDERSTANDING OF OFFICE POLICIES

I have read and understand the above statements and agree to be bound by its terms and conditions. I also understand and agree that such terms may be amended occasionally by the practice.

_____ _____

Patient Signature OR Authorized Representative *Date*

_____

Printed Name of Authorized Representative

St. Joseph's/Candler Medical Group

Appointments

- Appointments are generally scheduled Monday through Friday from 8:00am – 5:00pm.
- New patients must arrive 30 minutes prior to their first appointment with completed paperwork.
- Your insurance cards and picture ID will need to be presented each time you visit our practice to assure we have the most recent information.
- If insurance card is not provided, appointment will be handled as self-pay and payment for services will be collected prior to being seen.
- If you are a self-pay patient, payment is expected at time of visit. Patients paying out-of-pocket for services will get a 50% discount at check-out (excluding those injured due to Motor Vehicle Accidents and Worker's Compensation). If you feel you cannot pay at time of visit, please call your doctor's office for financial assistance or to make prior arrangements.
- If you are late the doctor's office reserves the right to reschedule your appointment for another day and time.

Cancellations

If you are unable to keep an appointment, please notify the office as soon as possible, preferably 24 hours prior to the appointment. This courtesy allows us to give appointments to another patient. If you do not cancel your appointment within 24 hours of your scheduled appointment a $35 fee will be charged to your patient account balance.

No-Shows

- A 'no-show" is someone who misses an appointment without canceling within 24 hours of their scheduled appointment time. Failure to present at the time of the schedule appointment will be recorded in the patient's record as a "no-show".
- If you do not show up or if you do not cancel your appointment within 24 hours of your scheduled appointment a $35.00 No Show fee will be added to your patient account balance.
- When three (3) "no-show" appointments have been documented you will receive a letter from the physician discharging you from the practice.
- We will offer 30 days of emergent care only and transfer your records when you find a new physician.

Insurance

- Due to changes in today's healthcare, your insurance may not always pay for all services. You will be responsible for paying any claims that are not covered by your insurance. Please call your insurance prior to appointment or services to ensure what will be covered and what won't. If you do not feel like you can pay for appointment or services, please call your doctor's office for financial assistance.
- As a courtesy to our patients we will file your insurance claims, therefore it is your responsibility to provide our office with up to date billing information.
- Medicare
- If you have MEDICARE please familiarize yourself with the items and services for which Medicare will not pay as they do not pay for all of your health care costs.
- When you receive an item or service that is NOT a Medicare benefit, you are responsible for payment, personally or through any other insurance that you may have.
- If you have questions please ask for the NEMB form-Notice of Exclusions from Medicare Benefits.

St. Joseph's/Candler Medical Group

Co-payments

- If your insurance plan requires a co-payment, our office will request payment prior to seeing the physician and/or at the time of service.
- For your convenience, we accept cash, check and most credit cards.

Self-Pay

- Self-pay patients are required to pay for services prior to being seen for their visit and will be balance billed for the remainder of the fees at the time of charge posting.
- For your convenience, we accept cash, check and most credit cards.
- Patients paying out-of-pocket for services will get a 50% discount at check-out (excluding persons injured in a Motor Vehicle Accident or Worker's Compensation). If you feel you cannot pay at time of visit, please call your doctor's office for financial assistance or make prior arrangements.

Patient Account Balance

If you have a patient account balance it must be paid in full prior to seeing the physician or service. You may call 912-819-7447 to check your account balance. If you have a balance but are unable to pay at time of appointment, please call your doctor's office for financial assistance.

Prescription Refills and Samples

- You must contact your pharmacy directly for more expedient prescription refills.
- Please allow your pharmacy up to 48 hours to process your refill request. The pharmacist may need to check with your physician.
- Please do not call the nurse and leave multiple messages about your refill as this will only delay the process of completing your refill request.
- Some prescriptions cannot be refilled if you have not seen your physician within the last 6 months.
- When you are being seen by your physician, please remind him/her to refill your medications at the time of your visit.
- If you have mail away prescriptions, please allow 7-10 business days for the necessary forms to be completed. It is very important you plan ahead with mail away prescriptions to allow us adequate time to get all the paperwork completed.

Laboratory and Test Results

- You must have an appointment for laboratory test and a lab order from your physician.
- If you think you need laboratory tests performed, but you don't have a lab order, please call your doctor's nurse.
- Your doctor must review all laboratory/tests results before they are released to the patient and filed in chart.
- Your doctor will report abnormal results or reports on special procedures or biopsies as soon as they are available. If you have not heard from us within 7-10 days, please call our office.

Referrals and Prior-Authorizations

- Most managed care plans require a patient be seen by their doctor prior to seeing a specialist.
- Referral and prior-authorization requests are handled here in the office.
- Please allow at least 7-10 business days for non-urgent requests.
- You will be notified when the request has been approved and the appointment has been made.
- Referrals will not be handled after-hours or on weekends.

Medical Records

Please note that requests for any health information cannot be processed without a signed Medical Record Release from the patient or legal representative.
A fee may be charged for this service.
This service is outsourced and processed weekly.
Please allow up to 10-14 business days for your request to be processed.

Returned Check Policy

Returned checks made payable to this office for insufficient funds, stop payments or other reason for non-payment will be assessed a $30.00 NSF fee for which the patient will be held responsible.