2005 C Pioneer St
Waycross, GA 31501
Phone:(912)490-7777
Fax: (912) 490-7778

PATIENT INFORMATION

DATE: _____

FIRST NAME: _____MI: _____ LAST:_____

NICKNAME/NAME CALLEDBY: _____

DOB: _____ SSN: _____-_____-_____ GENDER: MALE / FEMALE

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME: (____) _____ CELL: (____) _____EMAIL: _____

EMPLOYER: _____ WORK PHONE: (____) _____

ADDRESS, CITY: _____STATE: _____ZIP: _____

MARITAL STATUS: (Circle) SINGLE MARRIED DIVORCED WIDOWED LIFE PARTNER OTHER: _____

SPOUSE: _____ SPOUSE DOB: _____

SPOUSE EMPLOYER/OCCUPATION: _____ _____

WORK PHONE: (____) _____CELL PHONE: (____) _____

EMERGENCY CONTACT

Name: _____ Relation: _____Contact (___) _____

I authorize Faith Family Practice to communicate my health information with the following:

Name: _____ Relation: _____Contact (___) _____

Name: _____ Relation: _____Contact (___) _____

Patient/Guardian Signature: _____ Date: _____

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INSURANCE INFORMATION

Person responsible for bill: _____ DOB: _____

Address (If different) _____ Contact: (___) _____

Employer: _____ Employer Contact: (___) _____

Employer Address: _____

Primary Insurance Carrier: _____

Policy# _____ Group# _____

Policy Holder Name: _____ DOB: ____/____/_____

Policy Holder SSN: _____-_____-_____ Patient's relationship to subscriber: _____

Secondary Insurance Carrier: _____

Policy# _____ Group# _____

Policy Holder Name: _____ DOB: ____/____/_____

Policy Holder SSN: _____-_____-_____ Patient's relationship to subscriber: _____

A COPY OF ALL INSURANCE CARD(S) & DRIVER LICENSE WILL BE REQUESTED AT EACH VISIT

PAST MEDICAL HISTORY

Circle all that apply

Heart Disease Hypertension Heart Attack High Cholesterol Stroke COPD

Diabetes - Type I / Type II Asthma Thyroid Disease GERD Liver Disease

Kidney Disease Gout Arthritis Migraines ADD/ADHD Cancer

LIST ALL OTHER MEDICAL ISSUES: _____

Age or Year of last Colonoscopy? _____

Age or Year of last Bone Density? _____

Age or Year of last Mammogram? _____

Age or Year of last Pap Smear? _____

SURGICAL HISTORY

Have you had any surgeries, if yes, please list: -ATTACH A LIST IF NEEDED

TYPE: _____ YEAR: _____

TYPE: _____ YEAR: _____

TYPE: _____ YEAR: _____

TYPE: _____ YEAR: _____

Family History

Mother Still Living? (Circle) Yes No Health Problems: _____

Father Still Living? (Circle) Yes No Health Problems: _____

Brother Still Living? (Circle) Yes No Health Problems: _____

Sister Still Living? (Circle) Yes No Health Problems: _____

Social History

Do you smoke cigarettes? YES / NO Current: Packs/day_____ How long? _____

Do you use other tobacco? YES / NO Type: _____ How long? _____

Do you vape? YES /NO How long? _____

Do you drink alcoholic beverages? YES / NO Weekly Amount? _____

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MEDICATIONS

Local Pharmacy:_____ **Mail order Pharmacy:** _____

Medication: _____ Dose: _____ Frequency: _____

Medication: _____ Dose: _____ Frequency: _____

Medication: _____ Dose: _____ Frequency: _____

Medication: _____ Dose: _____ Frequency: _____

Medication: _____ Dose: _____ Frequency: _____

Medication: _____ Dose: _____ Frequency: _____

Medication: _____ Dose: _____ Frequency: _____

Medication: _____ Dose: _____ Frequency: _____

Do you have allergies to any medication? YES / NO

If YES, Please list:

Medication Allergy: _____ Reaction: _____

Medication Allergy: _____ Reaction: _____

Medication Allergy: _____ Reaction : _____

Are you allergic to Latex? YES / NO

Other Allergy: _____

Other Allergy: _____

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Dr. Clay Lee, D.o. Jerry Mullis, M.D.

Bradley Page, PA-C Roxy J Sheffield, PA-C Leanna L. Lewis, FNP

Tayler Allen, PA-C Dillon Veal, PA-C

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____ DOB: _____

Request the release of my Medical Records from:

Physician Office: _____

Address: _____

Phone: _____ Fax: _____

Records to be released to Faith Family Practice.

(Records to include: a photographic copy of one year of office notes, most recent labs, x-ray reports and colonoscopies)

Patient/Guardian Signature: _____

Date: _____

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FINANCIAL POLICY

As your physician, we are committed to providing you with the best possible medical care. To achieve this goal, we need your assistance and your understanding of our payment policy.

PAYMENT IS DUE AT TIME OF SERVICE

Please understand ALL New Patient appointments are required to pay Insurance co-pay or Self-Pay deposit of $50 AT THE TIME OF SCHEDULING & if you No-Show that is NON REFUNDABLE.

All co-pays, deductibles and the percentage you are responsible for, **is due at time of service**. If you are **Self-Pay,** you MUST pay the Self Pay price in full at the time of visit, unless other arrangements have been made with the Practice Manager, prior to your visit.

We must be listed as the PCP, Primary Care Physician on your insurance card, or you will be considered Self-Pay for that visit.

If your account has an outstanding balance of $5.00 or less, you will NOT receive a statement in the mail. You will be notified of the balance on your next visit.

We accept Cash, Check, Master Card, and Visa. You will be charged a service charge of $35 for returned payments due to NON-SUFFICIENT Funds and you may also lose your privilege to write checks in our office.

CHILDREN OF DIVORCED PARENTS

Payment is due at time of service- Regardless of who is responsible by order of the Divorce Decree.

NO SHOW APPOINTMENTS

Patients who do not cancel and NO SHOW for your appointment you will be charged a $25.00 NO SHOW Fee.

WORKERS COMPENSATION AND AUTOMOBILE ACCIDENTS

We **DO NOT** accept workers compensation or automobile accident claims. If this is the case, you are responsible for your account at the time of service.

My signature below indicates that I have read and understand the financial policy and appointment policy.

Signature: _____ Date: _____

Printed Name: _____

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

With my consent, Faith Family Practice, LLC, may use and disclose protected health information (PHI) about me to carry out treatments and healthcare operations (TPO). Please see Faith Family Practice's Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Faith Family Practice reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by sending us a written request to the Privacy Officer, Faith Family Practice, 2005-C Pioneer St. Waycross, GA 31501.

With my consent, Faith Family Practice, may call my home or other designated location and leave a message on voicemail or in person in reference to any Items that may assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results and other test results.

With my consent, Faith Family Practice may mail to my home or other designated location any items that assist in the practice carrying out TPO, such as appointment reminder cards, and patient statements as long as they are marked Personal and Confidential.

With my consent, Faith Family Practice may email to the email address I have on file any items that assist the practice in carrying out TPO, such as appointment reminders, patient statement information and other things. have the right to request that Faith Family Practice restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it Is bound by this agreement.

By signing this form, I am consenting to Faith Family Practice's use and disclosure of my PHI to carry out TPO. may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Faith Family Practice may decline to provide treatment to me.

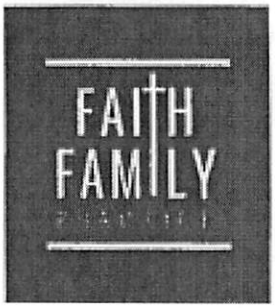
Patient's Name: _____ Date of Birth: _____

Signature of Patient or Legal Guardian: _____ Date: _____

Print Name of Legal Guardian:_____

••ALL PAYMENTS, COPAYMENTS AND DEDUCTIBLES ARE DUE AT TIME OF SERVICE••

PLEASE BE SURE TO COMPLETE ALL FORMS



Consent for Treatment

1. _____ (patient name) give permission for **Faith Family Practice** to administer medical treatment as deemed necessary by the medical provider on call.

2. I give **Faith Family Practice** permission to file insurance benefits for the care I receive.

I also understand that:

- **Faith Family Practice** will have to send my medical record information to my insurance company.
- I am responsible for all Co-pays and the percentage as required by my insurance, **at the time of service.**
- I understand that I am responsible for the cost of these services if my insurance does not pay.

3. I understand that if I Don't have insurance, I am considered **Self-Pay,** and I am responsible for the payment of services before services are rendered.

- I also understand that as a Self-Pay patient I am responsible for any medications and or procedures performed during this visit. These charges are expected to be paid prior to my leaving the facility.

4. I understand:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my clinician.

Patient's Signature _____ Date _____

Parent/Guardian Signature _____ Date _____
(Children under 18)

Print Name _____ Date _____

Witness (Staff) _____ Date _____

FAITH FAMILY PRACTICE
2005-C PIONEER STREET
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URINE DRUG SCREEN (UDS) PROTOCOL

Basic UDS: The test is medically necessary to determine the presence or absence of drugs or **drug** classes in a urine sample

Definitive UDS: The test is medically necessary to identify specific medications, illicit substances and metabolites. This test Is being used to identify a specific substance or metabolite that is in a large class of drugs or that is inadequately detected or not detected by Presumptive UDS, and to identify drugs when a definitive concentration of a drug is needed to guide management.

Definitive **UDS:** This test is medically necessary to identify non-prescribed medication or illicit use for ongoing safe prescribing of controlled substances.

Definitive **UDS:** This test is medically necessary to rule out error as the cause of a Presumptive UDA result.

Definitive UDS: This test is medically necessary to identify a negative, or confirm a positive, Presumptive UDS result that Is inconsistent with a patient's self-report, medical history, presentation, or current prescribed medication plan.

Definitive UDS: This test is medically necessary for use in a differential assessment of medication efficacy, side effects or drug-drug interaction.

Non-opioid alternatives for the treatment of pain have been discussed with the patient. A treatment plan has been created and discussed with the patient. A physical exam, assessment of patient compliance with **opioid** agreement, family/social assessment, opioid risk tool, and an assessment of the **POMP** were utilized.
The **opioid** risk tool categorized the patient as "low risk" **meaning** that the patient has a low likelihood of aberrant drug-related behavior and therefore should undergo testing 1-2 times every 12 months.

The opioid risk tool categorized the patient as "moderate risk" meaning that the patient has a reasonable likelihood of aberrant drug-related behavior and therefore should undergo testing 1-2 times every 6 months.

The opioid risk tool categorized the patient as "high-risk" meaning that the patient has a high likelihood of aberrant drug-related behavior, Including the use, misuse, and/or abuse of prescribed medications, non-prescribed medications and/or Illicit- controlled substance, as well as diversion, and therefore should **undergo** testing 1-3 times every 3 months.

Change In frequency of UDS: A change In the frequency of UDS testing is medically necessary because of the need to assess patient response to a newly prescribed medication, patient side effect profile has changed, drug-drug Interaction, sudden change In patient's medical condition, and/or patient admits to use of Illicit or non--prescribed controlled substance.

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DOCTOR TREATMENT & MEDICATION AGREEMENT

Faith Family Practice is primarily a Family Medical practice as opposed to a Pain Management practice.

The purpose of this
Agreement is to prevent misunderstandings about certain medicines that might be prescribed for pain management. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals.

This Agreement is essential to the trust and confidence necessary in a physician/patient relationship and the trust that the physician undertakes to treat the patient based on this Agreement.

By signing this agreement you will have read, understood, and agreed to these rules: • If I break this agreement, my doctor may stop prescribing my medications and I may **be DISCHARGED** from the practice.

• I will keep Faith Family Practice notified OF MY CURRENT PHARMACY AND THEIR **PHONE NUMBER.**

• I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

• I will not use ANY medications that were not prescribed to me or ILLEGAL substances (narcotics) (e.g., heroin, cocaine, methamphetamines, LSD.) • If recommended by the physician, I will submit to an evaluation by an addiction specialist, which may include a psychiatric evaluation and subsequent
treatment.

• I will not **SHARE,** SELL **OR TRADE my** medication with anyone.

- I will not attempt to obtain any controlled pain medication from any other doctor or practice.
- I will SAFEGUARD my pain medication from loss or theft. Lost or stolen medicines WILL NOT be replaced.
- Refills of my prescriptions for pain medication will be made only during regular office hours. All refill requests must be made THREE business days in advance. NO REFILLS WILL BE AVAILABLE DURING EVENINGS, WEEKENDS OR HOLIDAYS.
- I understand that I must be seen at a minimum of every NINETY DAYS to request a Schedule II controlled medication (opioid) refill, or my refill will be denied until I am seen.
- I authorize my doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, Including this state's **Board** of Pharmacy, In the Investigation or any possible misuse, sale or other diversion of my **pain** medicine. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.
- I authorize my doctor to provide a copy of this agreement to my pharmacy. • I will submit to a blood or urine test every NINETY DAYS and at any other time as requested by my doctor to determine compliance with my program of pain control medication.
- I will use my medicine at a rate no greater than the prescribed rate and that use of my medication

at a greater rate will result in my being without medication for a period of time.

- If at any time I break my medication contract, I am aware that the local Sheriff's Office may be notified, and my records could be released to them.

I agree to follow these guidelines that have been fully explained to me.
all of my questions and concerns regarding treatment and medications have been adequately answered. If requested, a copy of this Agreement has been given to me.

This Agreement has been reviewed and signed on this _____ day of _____

in the year of_____

Patient Name(printed): _____

Patient/Guardian Signature: _____

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PLEASE COMPLETE THE FOLLOWING

IF THE PATIENT IS UNDER 18

Patient Name _____ Date of Birth: _____

FATHERS

Name:_____ Date of Birth:_____

SS# _____-_____-_____

Address:_____ Phone (____) _____

City, State, Zip:_____

MOTHERS

Name:_____ Date of Birth:_____

SS# _____-_____-_____

Address:_____ Phone (____) _____

City, State, Zip: _____