# WALTON FAMILY MEDICINE, P.C.

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## PATIENT REGISTRATION FORM

**Name:_____ Birth Date:_____**

**Address:_____ Sex: ( )Male ( )Female**

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

**Race: White, African American, Asian, OR_____ Ethnicity: Hispanic, Not Hispanic, OR_____**

**Email address_____**

**Primary Phone:_____ home/ cell/ work**

**Secondary Phone_____ home/ cell/ work**

**Marital Status _____Single _____Married _____Divorced _____ Widowed**

**Employed-Occupation:_____ _____Retired _____Disabled**

**Emergency Contact:_____ Relation:_____**

**Phone:_____**

**Guarantor Information: (who is responsible for bill - put self if patient)**

**Name:_____ Relation:_____**

**Address:_____**

**City_____ State:_____ Zip:_____**

**Insurance Coverage:**

**Name of Policy Holder_____ Date of Birth_____**

## AUTHORIZATION STATEMENT

I authorize the release of any medical information, including related psychiatric care, drug and alcohol abuse, and AIDS/HIV confidential information, necessary to process insurance claims. I understand and agree that I am responsible for payment of all charges, regardless of insurance coverage. I agree to accept full responsibility for charges that are not covered by insurance and/or Medicare providing that they are deemed necessary, and I agree to have the services rendered in advance of this financial understanding. It is my responsibility to keep the office updated regarding address, phone number and insurance changes. Our office reserves the right to charge patients for cancellations not made at least 12 hours prior to visit and for no show visits. For regular visits there will be a $50 charge and for physical/preventative visits there will be a $100 charge.

SIGNED: _____ DATE: _____

Patient's Name: _____ Date of Birth: _____

Do you have any of the following:

___ Diabetes ___ heart disease ___ Stroke ___ Depression ___ lung disease- What type: _____

___ High Blood Pressure ___ High Cholesterol ___ Cancer- if yes what type: _____

Other: _____

Significant health problems in your family history:

___ Diabetes ___ heart disease ___ Stroke ___ Depression ___ lung disease- What type: _____

___ High Blood Pressure ___ High Cholesterol ___ Cancer- if yes what type: _____

Other: _____

Surgical History:

| Previous surgery | Dates | Previous surgery | Dates |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Social History:

Do you drink caffeinated beverages? _____ Yes _____ No (*if yes how often*) Per__ day __ Week __ month

Do you drink alcoholic beverages? _____ Yes _____ No (*if yes how often*) Per__ day __ Week __ month

Do you smoke, vape, chew tobacco, or take any other illicit drugs? ___ Yes ____No

(*If yes how often*) Per__ day __ Week __ month

Please provide the most recent date for the following health maintenance and where service was provided:

Colonoscopy: _____

Mammogram: _____

Pap Smear: _____

Bone Density: _____

Eye Exam: _____

List any other doctor/specialist:

_____ _____

_____ _____

_____ _____

Patient Name: _____ Birth date: _____

List your preferred pharmacy: _____ City: _____

Please List all current medication, dosage, and strength.

| | **Name of Medication** | **Milligram** | **Frequency** |
|---|---|---|---|
| 1. | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ |
| 3. | _____ | _____ | _____ |
| 4. | _____ | _____ | _____ |
| 5. | _____ | _____ | _____ |
| 6. | _____ | _____ | _____ |
| 7. | _____ | _____ | _____ |
| 8. | _____ | _____ | _____ |
| 9. | _____ | _____ | _____ |
| 10. | _____ | _____ | _____ |

Please list any allergies to Medications or latex:

_____

_____

_____ _____

*(Signature of responsible party)* *(Date)*

# AUTHORIZATION TO RELEASE MEDICAL INFORMATION

**(This is any family member or friend who may pick up any prescriptions or any medical records on your behalf)**

I, _____authorize Walton Family Medicine, P.C. to:
(Patient or legal guardian if patient is a minor)

(MARK ALL THAT APPLY):

_____ release my test results.

_____release medication(s) requested.

_____release written prescriptions, copies of forms or records that I have requested.

_____release information concerning appointments and referrals.

TO THE FOLLOWING PEOPLE: (spouse, children, friends, other relatives)

_____
(List any and all names)

OR

I, _____DO NOT authorize anyone other than myself to receive any of my medical information.

I, _____DO _____DO NOT authorize you to leave messages on my home answering machine regarding appointments and referrals or to inform me that test results are available. NOTE: You must call the office to get test results, we do not leave results on the answering machine.

I, _____DO _____DO NOT authorize you to contact me or leave messages at my place of work.

**I understand that this authorization shall remain in effect until revoked by me in writing and that I may amend this agreement at any time.**

_____ _____
SIGNATURE OF PATIENT DATE

# Consent to the Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations

I, _____understand that as part of my healthcare, Walton Family Medicine, P.C. (WFM) originates and maintains health records describing my health history, symptoms, examinations, test results, diagnoses, treatment, and plans for future and 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 surgical information to my bill
- A mean by which a third-party payer may verify that services billed were provided,
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and agree, by my signature below, that I have received a copy of WFM's "Notice of Privacy Practices for Protected Health Information," which provides a more complete description of information, uses and disclosures, prior to signing this consent. I understand that WFM may change its "Notice of Privacy Practices for Protected Health Information" from time to time and that notice of such changes will be provided upon request.

I understand that I have the right to request restrictions as to how my Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations. I understand and agree that WFM is not required to agree to any restrictions that I may request, but, if WFM agrees, WFM will be bound by that restriction.

I understand that I may revoke this consent by notifying WFM in writing that I revoke this consent unless WFM has used or disclosed my Health Information in reliance on this Consent.

I understand and agree that WFM has the right to disclose relevant Health Information to my immediate family members, other relatives, close or personal friend or anyone identified by me.

_____

(Printed Name of Patient or Legal Representative)

_____ _____

**(Signature of Patient or Legal Representative)** **Date**

# ATTENTION PATIENTS

WORK ORDERS:

If you are given any kind of work order for any type of lab work, x-ray, MRI, CT, ultrasound, physical, speech, or occupational therapy, you MUST call your insurance company to verify that they will cover the test and location of the services requested. We are finding that many insurance plans have exclusive agreements and will only pay for services at certain places. If you do not follow the directions of the insurance company and you obtain services at a different location, then:

*YOU WILL GET A BILL AND WE MAY NOT BE ABLE TO ASSIST YOU IN CORRECTING THE BILL.*

We do not want this to happen to you. Therefore, it is YOUR RESPONSIBILITY TO BE CERTAIN that you use whatever network, laboratory, or facility your insurance insists you use.

YEARLY PHYSICALS:

If you are here for a yearly physical, then all charges (including any labs) *will be processed as a Wellness/Preventative Exam.* IT IS YOUR RESPONSIBILITY to call the customer service department of your insurance company to determine what (if any) portion they will pay for a physical.

SICK VISITS AND ROUTINE FOLLOW UP VISITS:

All charges which are related to a diagnosis or health problem will be coded as such. A diagnosis or health problem can only be coded as a problem. You are not "well" if you are here to discuss problems with our physicians.

*YOU ARE RESPONSIBLE FOR UNDERSTANDING YOUR INSURANCE BENEFITS. LACK OF KNOWLEDGE OF YOUR BENEFITS COULD COST YOU MONEY!*

I understand that any charges not covered by my insurance will be my financial responsibility. I have read and understand the office policies listed above.

_____ _____

Signature of Patient or Guardian Date

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## Medical Record Release

Patient name: _____

Date of Birth: _____ SSN: _____

**Release from:**

Facility/ Practice name: _____

Phone: _____ Fax: _____

Address: _____

**Purpose of release:**

_____ on-going care _____ office notes _____legal _____other_____

**Check specific information to be released:**

_____ All _____ office notes _____ labs _____ X-ray _____ other

Dates of service from: _____ to _____

**Release to:**

Facility Name: Walton Family Medicine_____

Phone: 770-267-7093_____ Fax: 770-267-7361_____

Address: P.O Box 671 Monroe, Ga 30655_____

Email: jmorris@waltonfamilymedicine.com

PATIENTS' RIGHTS AND SIGNATURE: I understand that I have a right to revoke this authorization at any time except to the extent that action has previously been taken in reliance thereof. I understand that the information used/disclosed pursuant to this authorization may be redisclosure by the recipient and no longer protected. This authorization will expire 1 year from the day of original date of signature. The records may include psychiatric/ HIV/ drug/ alcohol abuse records.

**PRINT NAME:** (Parent/ Authorized Representative) _____

**Signature**: _____ Date: _____