Northeast Georgia
PHYSICIANS GROUP

PATIENT REGISTRATION FORM

Date:	Reason for Visit:

LAST NAME	FIRST NAME	MIDDLE NAME

SOCIAL SECURITY #	SEX	I IDENTIFY MYSELF AS:	BIRTH DATE (mm/dd/yyyy)	
	❑ Male ❑ Female	❑ Male ❑ Female ❑ Other: ___________		

MAILING ADDRESS	CITY	STATE	ZIP

HOME PHONE	WORK PHONE	MOBILE PHONE	E-MAIL ADDRESS

MARITAL STATUS	INTERPRETER NEEDED?	PREFERRED LANGUAGE	RACE	ETHNICITY
❑ M ❑ S ❑ D ❑ W	❑ Yes ❑ No		❑ Black ❑ White ❑ Asian ❑ Other	❑ Hispanic ❑ Non-Hispanic

RELIGION	COMMUNICATION PREFERENCE	PRIMARY CARE PHYSICIAN
	❑ Mail ❑ Phone ❑ Email ❑ Patient Portal	

EMPLOYER INFORMATION

PATIENT'S EMPLOYER	OCCUPATION	WORK PHONE

BUSINESS ADDRESS	CITY	STATE	ZIP

EMERGENCY CONTACT INFORMATION

NAME	RELATIONSHIP	HOME PHONE	WORK PHONE	MOBILE PHONE

GUARANTOR INFORMATION (IF PATIENT IS UNDER 18 YEARS OLD)

GUARANTOR'S NAME	RELATIONSHIP	SOCIAL SECURITY #

ADDRESS (IF DIFFERENT FROM ABOVE)	DATE OF BIRTH	SEX

EMPLOYER	HOME PHONE	WORK PHONE	MOBILE PHONE

EMPLOYER'S ADDRESS	CITY	STATE	ZIP	NAME OF ADULT PRESENTING MINOR FOR TREATMENT	RELATIONSHIP

INSURANCE INFORMATION

INSURANCE COMPANY (PAYOR)	SUBSCRIBER NAME	DATE OF BIRTH	SOCIAL SECURITY #	SUBSCRIBER ID	GROUP ID	PATIENT RELATIONSHIP TO SUBSCRIBER
SECONDARY INSURANCE (PAYOR)	SUBSCRIBER NAME	DATE OF BIRTH	SOCIAL SECURITY #	SUBSCRIBER ID	GROUP ID	PATIENT RELATIONSHIP TO SUBSCRIBER

INJURY/ACCIDENT INFORMATION (IF APPLICABLE)

❑ Auto/MVC ❑ Worker's Comp ❑ Other Accident:

DATE	TIME	PLACE	NATURE

Who may we thank for referring you to our office?

How did you hear about our office?

PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARD(S) AND DRIVER'S LICENSE.

Northeast Georgia
PHYSICIANS GROUP

CONTROLLED SUBSTANCE AGREEMENT

Patient Name: ______________________________ **Birth Date:** ____________ **Chart #** ______________________

My physician and I have a common treatment goal to improve my ability to function and/or work. In consideration of that goal, I am being treated with medications such as (narcotics, sedatives, muscle relaxants, stimulants, and/or barbiturates). These medications may impair my alertness, reflexes, coordination and judgment. The use of many of these types of medications is controlled and monitored by local, state and federal agencies. These medications can be highly effective when taken as directed under medical supervision but have the potential for abuse and misuse.

I have been informed that psychological dependence, physical dependence and addiction to controlled substances can occur. If this happens, I will follow my physician's guidance and participate in any treatment programs recommended; which could include referral to a substance abuse treatment program or facility, psychological counseling and/or medical treatment.

I agree to always be truthful with all my physicians regarding my history, illness, and use of medication.

I have never been diagnosed with or treated for a substance abuse problem. If this is not a true statement, please explain:

____

____

I have never been involved in the illegal sale, possession or transportation of controlled substances.

I understand that the giving or sale of my prescription medication to any other person is illegal and may result in my dismissal from this practice as well as being reported to a law enforcement organization.

I understand I should not consume alcohol with taking these types of medications.

I take full responsibility for the consequences of driving a motor vehicle, operation of machinery or performing any other activity in which alertness, reflexes, coordination and/or judgment are necessary.

I Agree To Abide By The Following Conditions:

a. I will follow the treatment plan that my physician and I have agreed to.
b. I will report any suspected side effects to my physician immediately.
c. I understand that my physician is not obligated, nor will he/she automatically refill prescriptions for controlled medications that I have been receiving from another physician.
d. I will not ask for nor accept controlled substance medications or prescriptions from any other individuals or physicians while I am receiving such medication from this physician's office. This is not only illegal but could endanger my health. The only exception to this would be if I were hospitalized.
e. I will take the medications as directed. If I use my medication up sooner than prescribed, I understand they will not be refilled until it is time for the scheduled refill.
f. I will bring the unused portion of my medication to the office for a medication count if requested by my physician.
g. In the event that my prescription needs to be changed to another medication, I understand I may be asked to return the remaining portion of the prior prescription for disposal.
h. I understand my medication dosage may need to be increased or decreased depending upon my condition. I will not adjust my medication myself and understand if I need more medication due to a worsening of my condition, I must see my physician to be re-evaluated before my medication will be increased.
i. I understand to stop taking medications abruptly may be dangerous and lead to withdrawal symptoms. If medications need to be discontinued, I will follow my physician's supervision.

...CONTINUED ON PAGE 2

Northeast Georgia
PHYSICIANS GROUP

CONTROLLED SUBSTANCE AGREEMENT

I Agree To Abide By The Following Conditions:

j. **I agree to participate in a drug monitoring program to ensure that I am in compliance with this agreement. Monitoring may include random pill counts and random drug screening of urine, saliva, sweat, or blood samples to be provided by me on a random basis. Random monitoring is not limited to sampling at scheduled office visits but also may include sampling in between visits. Failure to comply with the monitoring program may disqualify me from further opioid or other controlled substance prescribing. I understand that I will be financially responsible for any testing required.**

k. **I understand that if my drug screen result reveals any or all of the following:**

   i. **the presence of non-prescribed controlled substances,**

   ii. **the absence of prescribed controlled substances,**

   iii. **the presence of drugs considered illegal in the state of Georgia for the treatment of your painful condition (THIS CURRENTLY INCLUDES MARIJUANA)**

   I may be disqualified from further treatment with prescription opioids (i.e. narcotics) by my current NGPG physician.

l. **I understand that rules as issued by the Georgia State Board of Medical Examiners may require that I see my prescribing physician at least every 3 months, or more frequently if mandated by the treating physician, to assess my condition and compliance with controlled substance treatment regimen. If I am unable to return to the office during the 90-day period due to a severe hardship, then I agree to provide written documentation of the hardship.**

m. I authorize my physician and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including the board of pharmacy, in the investigation of any possible misuse, sale or other diversion of my controlled medications. I authorize my physician to provide a copy of this Agreement to my pharmacy. I also authorize my pharmacy to provide records documenting prescriptions that I have received to my physician if requested. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

n. I understand I am responsible for my medications. If my medications or prescription is lost, misplaced, stolen or disappear for any reason, they will not be replaced until the scheduled refill date.

o.I am responsible for keeping track of the amount of medication and will plan ahead for refills in a timely manner, so I will not run out of my medication. I understand that these types of medications will only be refilled during regular business hours by my physician. They will not be refilled by other physicians in the office, by phone, after hours, on weekends or holidays.

p. For Females: I am not pregnant and agree to utilize birth control at all times while taking these types of medications. I agree to notify my physician immediately should I become pregnant. I accept the risk to my baby and myself if I should use these medications while pregnant.

My signature below means I have read and understand the terms of this agreement and have had any questions answered to my satisfaction. I understand if I violate this agreement, my controlled substance prescriptions and/or treatment by this provider may be terminated immediately. I further understand that violating this agreement is grounds for dismissal from the group.

Date: ____________________ Patient Signature: ____

MRN: ____________________ Printed Name: ____

Physician Signature ______________ : ____

Northeast Georgia
PHYSICIANS GROUP

ANNUAL CONSENT / AUTHORIZATIONS

Patient Name: ______________________________ DOB: ______________

Consent for Treatment:

- Permission is hereby given for any medical / surgical procedures, x-rays, drug or laboratory test, medication, or exam as may be deemed necessary by the Physician, Physician Assistant, Nurse Practitioner, or Nurse Midwife.
- I understand I have the right to see a Physician if I so choose, and have the right to see a Physician prior to any prescription drug or device order being carried out by an Advanced Practitioner.
- In the case of an unemancipated minor, the consent below is being given on his or her behalf.

Consent to Release Medical Information to a Spouse, Family Member or Significant Other:

Tell us with whom we may discuss your protected health information:
(Name and relation-Example: Jane Doe, Wife; Jan Doe, Daughter)

1) ______________ 2) ______________ 3) ______________

- *If you do not authorize information to be released to anyone please check this statement.*

❑ **I do not authorize any information to be released to anyone other than myself.**

I hereby authorize messages to be left on a voice mail system or answering machine. Please indicate the number(s) NGPG staff can utilize to leave a message for you:

1) ______________ 2) ______________ 3) ______________

- *For Medical Records release, see form C-45.*

Financial Responsibility:

I understand it is the responsibility of each patient to arrange for payment for the medical services received in this office. I hereby authorize any insurance benefits to be paid directly to Northeast Georgia Physicians Group, and recognize my responsibility to pay for all non-covered services. I also authorize the release of any information necessary to process an insurance claim. Charges for all minors are the responsibility of the parent, guardian, or individual presenting the child for treatment.

I hereby authorize Northeast Georgia Physicians Group, or any of its affiliates, agents, contractors or business associates, to contact me (by any telephone numbers, email addresses or other contact points provided by me or on my behalf) by the use of any automatic dialing system, by pre-recorded forms of voice/messaging systems, by electronic mail owned or used by the guarantor/responsible party, by text messages, by telephone or by cell phone for reasons related to the services I received at Northeast Georgia Physicians Group or payment for the services I received at Northeast Georgia Physicians Group including but not limited to, debt collection purposes.

Acknowledgment of Receipt of Nondiscriminatory Act Notice:

☐ By initialing, I acknowledge that I received a copy of the Nondiscriminatory Act Notice.

Acknowledgement of Privacy Rights:

By signing below I acknowledge that I am aware of the NGHS Notice of Privacy Practices and Individual Rights. We may use or share your medical information with personnel involved in your care at the Health System. We may also disclose your medical information to people outside of the System, such as Health Information Exchanges. NGHS Notice of Privacy Practices contains more information about the policies and practices protecting the patient's privacy.

I acknowledge that I have read the above, am giving my consent to the above, and am acknowledging I have been informed of my rights to privacy.

Signature: ______________________________ **Date:** ______________

Print Name: ______________________ **Email address:** ______________________

Northeast Georgia
PHYSICIANS GROUP

MEDICAL RECORDS REQUEST

Patient FULL Name:		Patient Date of Birth:	
Requestor Name: (note "n/a" if patient is the requestor)		**Relationship to Patient:** (note "n/a" if patient is the requestor)	

I hereby authorize the provider or group named below:

Provider/ Group Name:		Phone:	
Address, City State, Zip:		**Fax:**	

to disclose protected health information from the medical record of the above-listed patient, as noted here (check only ONE appropriate box):

	Entire Medical Record:	this includes specific permission to release **ALL RECORDS** and other information regarding: psychological notes, drug or alcohol abuse notes, AIDS and other STD related information, all laboratory and x-ray reports, consultation reports, surgical reports and other outpatient reports.
	Only specific information/specific time period:	

This information is to be disclosed to the following:

Patient/Provider/Group Name:			
Address, City State, Zip:			
Phone:		**Fax:**	

(please check ONE appropriate box)

The purpose of this disclosure is:		Continuing Care		Legal		Insurance		Personal		Transfer to another physician

- ❏ I understand that the information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of the information and may then no longer be protected by the federal privacy regulations.
- ❏ I understand this Authorization is specific to the information requested above.
- ❏ I understand I have a right to obtain a copy of this authorization by written request to NGPG and to obtain a copy from each health care provider, health care facility, or health plan to which the Authorization is presented.
- ❏ I understand this authorization will automatically expire within 90 days from the above stated date. I understand I can revoke this authorization in writing any time prior to this date; however, my revocation will not be effective until received and does not apply to information already provided prior to the revocation becoming effective.
- ❏ No health care benefits depend upon whether I sign the Authorization.
- ❏ An original as well as a photocopy of this Authorization authorizes the disclosure of the information I have authorized to be disclosed. I understand information may be disclosed my mail or fax.
- ❏ I understand that there may be a copy charge and upon request may obtain the fee schedule.
- ❏ I have read and understand this Authorization and have voluntarily signed said authorization.

I would like to receive my records:		in paper format		Electronically	If electronically, provide email:	

Signature:		Printed Name:	

Signer is:		Patient		Authorized Representative	Date:	

PLEASE MAKE SURE ALL SHADED AREAS ARE FILLED IN AS WE ARE UNABLE TO PROCESS INCOMPLETE FORMS

Northeast Georgia PHYSICIANS GROUP

SOLICITUD DE EXPEDIENTE MÉDICO

Nombre COMPLETO del paciente:		**Fecha de nacimiento del paciente:**	
Nombre del solicitante: (indique "n/a" si el paciente es el solicitante)		**Relación con el paciente:** (indique "n/a" si el paciente es el solicitante)	

Por medio de la presente autorizo al proveedor o grupo nombrado a continuación:

Proveedor/ Nombre del grupo:		**Teléfono:**	
Dirección, ciudad estado, código postal:		**Nº de fax:**	

a que divulgue información de salud protegida del expediente médico del paciente anteriormente mencionado, según se indica aquí (marque solo UN cuadro apropiado):

	Todo el expediente médico:	esto incluye permiso específico para divulgar **TODO EL EXPEDIENTE** y otra información sobre: notas psicológicas, notas sobre el abuso de drogas o alcohol, SIDA y otra información relacionada con las ETS, todos los informes de laboratorio y radiografías, informes de consultas, informes quirúrgicos y otros informes de paciente ambulatorio.
	Solo información específica o período específico:	

Se divulgará esta información al siguiente:

Nombre del paciente / proveedor / grupo:			
Dirección, ciudad estado, código postal:			
Teléfono:		**Nº de fax:**	

(marque UN cuadro apropiado)

La finalidad de esta divulgación es:		**Continuing Care**		**Legal**		**Seguro**		**Personal**		**Transferencia a otro médico**

- ❏ Entiendo que la información divulgada en virtud de esta autorización podría estar sujeta a su redivulgación por el receptor de esta información y que podría ya no estar protegida bajo las regulaciones federales de confidencialidad.
- ❏ Entiendo que esta autorización se trata específicamente de la información anteriormente solicitada.
- ❏ Entiendo que tengo derecho a obtener una copia de esta autorización por escrito a NGPG y a obtener una copia de cada proveedor de atención médica, establecimiento de atención médica o plan de salud al que se presenta la autorización.
- ❏ Entiendo que esta autorización vencerá automáticamente en un plazo de 90 días de la fecha anteriormente indicada. Entiendo que puedo revocar esta autorización por escrito en cualquier momento antes de esta fecha; sin embargo, mi revocación no entrará en vigencia hasta que se reciba y no se aplica a la información que ya fue proporcionada antes de que entrara en vigencia la revocación.
- ❏ Ningún beneficio de atención médica depende de si firmo esta autorización.
- ❏ Una original, así como también una copia de esta autorización autoriza la divulgación de la información que he autorizado para que sea divulgada. Entiendo que la información podría ser divulgada por correo o fax.
- ❏ Entiendo que podría haber un costo por la copia y cuando haga la solicitud puedo obtener el costo de ello.

Quisiera recibir mi expediente:		En papel		Electrónicamente, si lo quiere en este formato, proporcione un correo electrónico:	

Firma:		**Nombre impreso:**	

Firmado por:		**Paciente**		**Representante autorizado**	**Fecha:**	

ASEGÚRESE DE QUE TODAS LAS ÁREAS SOMBREADAS ESTÉN RELLENAS YA QUE NO PODEMOS PROCESAR FORMULARIOS INCOMPLETOS

FORM # NGPG 03407 (10/10/19)

Northeast Georgia
PHYSICIANS GROUP

Patient Financial Responsibility

Thank you for choosing Northeast Georgia Physicians Group (NGPG) for your medical care. We appreciate that you have entrusted us with your health care, and we are committed to providing you with the best patient care possible. The following information outlines our expectations for your financial responsibility to our office.

Patients or their legal representatives are ultimately responsible for all charges for services rendered. All services rendered to minor patients will be the responsibility of the accompanying adult, custodial parent or legal guardian.

NGPG is contractually obligated to collect applicable co-payments at the time services are rendered. We are also obligated to collect any deductible and/or co-insurance amounts deemed patient responsibility by your insurance.

Uninsured (self-pay), if you do not have health insurance, we will be happy to provide care for you. We offer a discount to uninsured patients of 30% on those services that would typically be billed to an insurance company. To qualify for a 45% discount (an additional 15%), we require a minimum of $100.00 to be paid at check-in ($25.00 for pediatric patients). This payment will be applied towards any charges for your visit. If there is an overpayment, outstanding balances will be settled, and the remainder will be refunded via return to credit card or by check (depending on the method of payment for the time of service deposit).

Procedure Deposit: Patients who are scheduled for a procedure may be required to pay a deposit towards their estimated patient responsibility amount. This amount would consist of any applicable copays, co-insurance, or any remaining deductible amounts. Our staff will contact your insurance company and provide you with an **estimate** of the planned procedure fee based on your plan benefits. The procedure deposit may be paid by cash, check or credit card.

You will also be contacted by hospital staff who will provide the same information for your expected hospital charges.

Please be aware that you may receive a statement from other entities such as anesthesia, lab, pathology, etc. Any questions you have regarding those charges would need to be directed to their office. NGPG does not process the billing for these services.

If you are unable to pay 100% of the estimate amount prior to your procedure, our staff will provide you with information about financing options. You will be required to make some type of payment towards your estimate amount prior to your procedure.

By signing this form, you agree that you have read and understand your financial responsibility.

______________________________ ____________________

Signature Date

Northeast Georgia
PHYSICIANS GROUP

POLICIES ACKNOWLEDGMENT

Please read over our payment policy below and initial where required.
Your initials tell us that you agree to comply with these parts of the policy.

Payment Policy _____ **Initials**

1. In compliance with new Federal law, we will ask you for photo identification and proof of health insurance at every visit. We may also take your picture the first time you visit our office.
2. It is not feasible for our staff be to fully aware of each health insurance plan's specific requirements or coverages. We will do everything we can to help you; however, it is your responsibility to verify that NGPG is part of your insurance plan's covered providers, and to know what your plan does and doesn't cover.
3. It is your responsibility to know what limitations your insurance plan may place on the number of times you can be seen in the office, have treatments performed, when referrals are required to receive care, or receive other types of health care.
4. Any charges you incur with us that are not paid by your health insurance according to our existing agreements will be your responsibility to pay. We will bill your insurance plan as a courtesy to you.
5. If you do not have health insurance, we will be happy to provide care for you. We offer a discount to uninsured patients of 30% on those services that would typically be billed to an insurance company. To qualify for a 45% discount (an additional 15%), we require a minimum of $100.00 to be paid at check-in ($25.00 for pediatric patients). This payment will be applied towards any charges for your visit. If there is an overpayment, outstanding balances will be settled, and the remainder will be refunded via return to credit card or by check (depending on the method of payment for the time of service deposit).
6. We will continue to provide care for you while you are paying off any outstanding balances owed. You will need to pay in full any charges you incur at the time of service while you are paying off outstanding balances. An exception may be made if your provider determines your visit is urgently needed. If you are unable to pay in full at the time of service, please ask about our payment options.
7. We do use a collection agency for accounts that fail to make a good faith effort to pay for the medical services we provide.

Prescription Refill Policy _____ **Initials**

Please allow 48 hours for all prescription refills. To speed up the process, please ask your pharmacy to send a refill request to the clinic.

Date of Birth______________

Medical Records Policy _____**Initials**

We are happy to provide you with a copy of your medical records. You must first provide a properly verified signed release of information for copies provided via email, CD, or on paper. A cost may be associated depending on the number of pages requested.

Changes in your Personal Information _____**Initials**

You are responsible for informing us of any changes to your name, address, telephone number, email address, or health insurance coverage. A failure to do so may affect your insurance coverage and/or our ability to provide you with important information about your health.

Patient Name____

Patient Signature____ Date:___________________

Parent/Legal Representative Signature:_________________________ Date:___________________

Northeast Georgia
PHYSICIANS GROUP

PATIENT NAME: ______________________________ DOB: ____________________

CURRENT MEDICATIONS

Please list all medications that you are currently taking (please include over the counter medications, herbals and any nutritional supplements)

DATE STARTED	MEDICATION NAME AND STRENGTH	DIRECTION FOR USE	REASON FOR MEDICATION	PRESCRIBING PROVIDER

PAST PSYCHIATRIC/MENTAL HEALTH MEDICATIONS

Please list ALL past Psychiatric/Mental Health medications you have tried in the past and why they did not work for you

MEDICATION NAME AND STRENGTH	DATE STARTED	DATE STOPPED	REASON FOR STOPPING MEDICATION

NGPG Psychiatry
200 Wisteria Drive
Gainesville, GA 30501
770-219-5407 • fax 770-219-7102

Client Information Form

Patient Name ____DOB_________________________

Legal Guardian(s)____Relationship_______________

Legal Guardian(s)____Relationship_______________

Other family members living at home (children, stepchildren, and other relatives):

Name	Date of Birth	Age	Relationship to Patient

1. ____
2. ____
3. ____
4. ____

Primary Care Doctor

Name of Practice & Provider ____

Medical/Psychiatric History

Current Medical Illnesses: ____

Past Medical Illnesses: ____

Medication Allergies: ____

Food Allergies: ____

Surgeries: ____

NGPG Psychiatry
200 Wisteria Drive
Gainesville, GA 30501
770-219-5407 • fax 770-219-7102

List any prior **psychiatric** treatment (inpatient, outpatient, testing) includes names, locations, and dates:

____

____

____

____

Family history of **psychiatric** illnesses:

____

____

Social history:

Work/school:____

Hobbies: ____

Reason for Visit

Primary symptoms or problems that led to this visit:

1. ____

2. ____

3. ____

Are there any safety concerns (i.e. suicidal gestures/attempts, self-injury, cutting, etc…)

____

____