MERCER Medicine

Dear New Patient,

Welcome and thank you for choosing Mercer Medicine, the clinical faculty practice of the Mercer University School of Medicine. We look forward to serving you.

We have prepared this packet of patient forms to make your check-in and patient experience as pleasant as possible. **Please complete this paperwork and bring it to your scheduled appointment.**

To help your visit go as smoothly as possible, **we encourage you to bring a list of all your current medications, insurance cards, driver's license, and office visit copay or deductible. Bring a state-issued identification card if you do not have a valid driver's license.**

Arrive at least 30 minutes before your scheduled appointment. Your appointment time indicates the time your doctor is scheduled to see you. You'll need to allow extra time to park, check in with our front desk, settle any copays, and complete necessary forms. Some providers may require you to reschedule your appointment if you do not arrive with enough time to complete these required tasks.

Date/Time of Appointment: _____

Provider Name: _____

Appointment Location: _____

***To avoid any scheduling delays, please arrive for your appointment by:** _____

By completing this patient information before your visit, you will help us provide you with more efficient and timely care during your visit. Thank you!

Sincerely,

Mercer Medicine Staff

MERCER Medicine

PERSONAL INFORMATION

Patient Name: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____ Cell: _____

Date of Birth: _____ Sex: Male / Female Social Security Number: _____

Email Address: _____ Married / Widowed / Divorced / Separated / Single

Spouse's Name: _____ Date of Birth: _____

Social Security Number: _____ Phone: _____

Primary Care Physician: _____ Pharmacy: _____

****Mercer Medicine has a contract with Quest Diagnostics. Please inform us if your insurance requires you to use a specific lab.**

**Health Insurance Provider In-Network Lab: _____

EMPLOYMENT

Employer: _____ Phone: _____

Occupation: _____

Spouse's Employer: _____ Phone: _____

Spouse Occupation: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact: _____

Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____

INSURANCE INFORMATION: *Please present your insurance card and driver's license on check-in.*

Primary Insurance: _____ Member Name: _____

Member Number: _____ Group Number: _____

Primary Insurance Phone: _____

Secondary Insurance: _____ Member Name: _____

Member Number: _____ Group Number: _____

Secondary Insurance Phone: _____

New patients only: How did you hear about us? _____

_____ _____

Signature of Patient or Patient Representative *Date*

MERCER Medicine

Patient Name: _____ Date of Birth: _____

Reason for today's visit: _____

PAST MEDICAL HISTORY: ***Check all medical problems you have or have had.***

Heart Disease	☐	GERD (acid reflux)	☐	Sickle Cell Disease/trait	☐
Coronary Artery Disease	☐	Inflammatory Bowel Disease	☐	Blood clot (DVT)	☐
Congestive Heart Failure	☐	Hypothyroidism	☐	Pulmonary Embolism	☐
Heart Attack	☐	Hyperthyroidism	☐	Cancer	☐
Heart Arrhythmias	☐	Osteoporosis	☐	Parkinson's Disease	☐
Atrial Fibrillation	☐	Diabetes	☐	Dementia	☐
Pacemaker/defibrillator	☐	Renal Failure	☐	Depression	☐
Heart valve problems	☐	Chronic Kidney Disease	☐	Bipolar	☐
High blood pressure	☐	Fatty Liver Disease	☐	Schizophrenia	☐
High cholesterol	☐	Kidney Stones	☐	Seizures	☐
Peripheral Vascular Disease	☐	Cirrhosis of the liver	☐	Rheumatoid Arthritis	☐
Carotid Stenosis	☐	Hernia	☐	Osteoarthritis	☐
COPD	☐	Stroke or TIA	☐	Lupus	☐
Asthma	☐	Anemia	☐	Glaucoma	☐
Sleep Apnea	☐	Low platelets	☐	Other:_____	☐

Past Surgical History: List all surgeries you have had and the date performed.

Date	Surgery	Date	Surgery

Diagnostic Testing and Procedures: Have you had any of the following items performed?

Test	Yes	No	Year	Location and Result
Echocardiogram (ultrasound of the heart)	☐	☐		
Stress Test	☐	☐		
Pulmonary Function Test (breathing test)	☐	☐		
MRI	☐	☐		
Colonoscopy	☐	☐		
DEXA (bone density test)	☐	☐		

MERCER Medicine

Patient Name: _____ Date of Birth: _____

Specialists involved with care: Please list any specialty physicians involved with your medical care (cardiologists, pulmonologists, nephrologists, neurologists, psychiatrists, endocrinologists, OB/GYNs, pain doctors, etc.).

Name of Doctor	Medical Specialty or reason for seeing

Please list any medications along with the doses that you take:

Medication	Strength/Dose	How often medication is taken

Do you have any allergies to medications?

Medication	Reaction Type

MERCER Medicine

Patient Name: _____ Date of Birth: _____

FAMILY HISTORY: *Please list your family's health problems to the best of your ability.* ☐ **I'm adopted**

Relative	Deceased? (if so, what age)	Medical Problems
Father		
Mother		
Paternal Grandfather		
Paternal Grandmother		
Maternal Grandfather		
Maternal Grandmother		
Brother		
Sister		

IMMUNIZATIONS: *Please list any vaccinations you have had.*

Year	Type of Vaccination/Immunization

SOCIAL HISTORY:

Do you smoke cigarettes or use a tobacco product? Y ☐ N ☐ How much per day? _____

Do you drink alcohol? Y ☐ N ☐ How much? _____

Do you use street or recreational drugs? Y ☐ N ☐ Which kind? _____

Do you use contraception? Y ☐ N ☐ What type? _____

Do you have or have you in the past had any communicable diseases (Ex. Syphilis, Hepatitis, HIV, Gonorrhea, Chlamydia, Herpes)? Y ☐ N ☐ If so, please list: _____

WOMEN ONLY:

Date of last PAP smear: _____ When is this due to be repeated? _____

Date of your last mammogram: _____

Have you ever been pregnant? Y ☐ N ☐ Number of live births? _____ Miscarriages? _____

At what age did you begin your period _____

Are you still having a menstrual period? Y ☐ N ☐ If so, when was your last menstrual period? _____

Have you entered menopause? Y ☐ N ☐

MERCER Medicine

PATIENT FINANCIAL AGREEMENT

Thank you for choosing Mercer Medicine for your healthcare needs. We are committed to providing you with quality and affordable healthcare. We ask all patients to review and sign this policy, asking questions as necessary. A copy will be provided to each patient upon request.

1. **Insurance:** We accept assignment and participate in most insurance plans. If your insurance is not a plan we participate in, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurer with any questions you may have regarding your coverage to receive the maximum benefit.
2. **COPAYMENTS: ALL COPAYMENTS ARE TO BE PAID AT THE TIME OF SERVICE. THIS ARRANGEMENT IS PART OF YOUR CONTRACT WITH YOUR INSURANCE COMPANY.**
3. **Registration:** All patients must complete our patient information form, which will be entered into our electronic health records (EHR) to maintain accurate information for proper billing. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information, or your insurance changes and you fail to notify us in a timely manner, you may be responsible for the balance of a claim. Most insurance companies have timely filing restrictions; if a claim is not received within the required timeframe, it can be rendered ineligible for payment and you will be responsible for the balance that remains.
4. **Patient Forms:** There will be a $25 fee for completion of various forms that require documentation and/or the provider's signature. This fee must be paid before the forms are completed. These forms require a minimum of 7 days for completion.
5. **Claims:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may not accept information from our office and may need information from you. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays or not. Your insurance benefit is a contract between you and the insurance company; we are not party to that contract.
6. **Collections:** Patient accounts with a balance due will receive monthly statements from our office. Please be aware that if a balance has remained unpaid for 120 days, it may be sent to our outside collection agency. If an account is sent to collections, it is the policy of this office to discharge the patient from the practice. You will be notified by mail that you will have 30 days to find alternative medical care. During that 30-day period our providers will be able to treat you only on an emergency basis.

AUTHORIZATION

- I authorize the release of any medical or other information necessary to process claims and/or appeals.
- I authorize Mercer Medicine to submit claims for benefits without obtaining my signature on each claim.
- I authorize payment of medical benefits to the providers of Mercer Medicine for services rendered.
- I have read, understand and agree to the provisions of this Patient Financial Agreement form.

_____ _____

Signature of Patient or Patient Representative *Date*

MERCER Medicine

Section I **Acknowledgement of Mercer Medicine Notice of Privacy Practices (updated August 2018)**

I, the patient, hereby acknowledge that I have been given the opportunity to ask any questions I may have regarding the Mercer Medicine Notice of Privacy Practices (NPP) and to request a copy, if desired.

_____ **Initial**

Section II **Acknowledgement of Mercer Medicine Prescription Policy**

I, the patient, hereby acknowledge that I have been given the opportunity to ask any questions I may have regarding Mercer Medicine's prescription policy and to request a copy, if desired. I understand that I must allow my physician **3 business days** to write or send my prescription to the pharmacy.

_____ **Initial**

Section III **Georgia Registry of Immunization Transactions & Services (GRITS)**

I, the patient, hereby accept or deny consent for my immunization data to be submitted to the Georgia Registry of Immunization Transactions and Services, which has been established to collect and maintain accurate, complete and current vaccination records to promote effective, and cost-efficient disease prevention and control.

_____ **Accept** _____ **Deny**

Section IV **MEDICARE PATIENTS ONLY: Georgia Physicians for Accountable Care (GPAC)**

Mercer Medicine is a participating member of the Georgia Physicians for Accountable Care Organization, a group of Georgia health care providers who voluntarily work together to coordinate care for Medicare beneficiaries like yourself. Because your physician is a member of GPAC, Medicare may share your health information with other physicians who are participating members of GPAC in order to provide you with the highest quality of care. If you do not wish to share your health information as part of GPAC, please ask a Mercer Medicine front desk staff member for a form to opt out of this program.

_____ **N/A** _____ **Accept** _____ **Deny**

Section V **Healthcare Formulary**

I, the patient, acknowledge that I am aware that Mercer Medicine could review my insurance provider's prescription formulary in order to prevent potential adverse medication effects.

_____ **Initial**

Section VI **Research**

To protect you and your privacy, your health information may be released by Mercer Medicine for research purposes only when you give your permission.

_____ **Accept** _____ **Deny**

Section VII Access to Protected Health Information

The people listed below may access my health records:

Name: _____

Relationship to Patient: _____

Name: _____

Relationship to Patient: _____

Section VIII Labs

****I, the patient, hereby acknowledge that I have been given the opportunity to ask any questions I may have regarding Mercer Medicine's partnership with Quest Diagnostics. I understand that I may be financially responsible for services I receive from an out of network lab provider.**

_____ **Initial**

Section X Patient Acknowledgement

I have read and understand all information provided on these forms.

_____ _____

Signature of Patient or Patient Representative *Date*