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: _____

_____ _____

Signature of Patient or Patient Representative *Date*

MERCER Medicine

Patient Name: _____ Date of Birth: _____

What is the reason for your visit today? _____

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

Heart disease	Blood disease	Bruise easy	Colon polyps
High blood pressure	Cancer	Breast lumps or mass	Anemia
Lung disease	Heart attack	Discharge from the breast nipple	Depression
Coronary artery disease	Heart murmur	Mitral valve prolapse	Vascular disease (blockages)
Arthritis	Kidney disease	Stroke	Diabetes
Ulcers	Dizziness	High cholesterol	Chest pain
Thyroid disease	Swelling in legs	Hernia	Hemorrhoids
Chronic cough	Heart failure	Kidney stones	Liver disease
Change in moles	Sinus problems	Slow healing sores	Varicose veins
Hearing loss	Eye disease	Glaucoma/cataracts	Positive TB test

Other: _____

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

Date		Date	

Diagnostic Testing: Have you had any of the following tests performed?

Test	Yes	No	Date	Where
Stress Test				
Echocardiogram (ultrasound of the heart)				
Cardiac Catheterization				
Chest X-Ray				

*If you have had any of these or other tests performed concerning your heart or today's visit, it is important that you bring a copy of these tests with you to your appointment.

Patient Name: _____ Date of Birth: _____

PATIENT MEDICATION SHEET:

Medication	Strength	How often medication is taken

Do you have any allergies to food/medications/environment? Y / N

If yes, please list: _____

_____

MERCER Medicine

Patient Name: _____ Date of Birth: _____

FAMILY HISTORY: *Please list your family's health problems.* **[ ] I'm adopted**

Relatives	Age	Deceased Y/N	What is the medical history?
Father			
Mother			
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			
Brother			
Sister			

SOCIAL HISTORY:

Do you smoke cigarettes/pipe/cigar/chew tobacco or dip snuff? Y / N How many per day? _____

Do you use street drugs? Y / N How much? _____

Do you exercise regularly? Y / N What types of exercise do you do? _____

IMMUNIZATIONS: *Please list any recent vaccines you have had. (Example: flu shot)*

Date	Type of Immunization

MEN ONLY:

Have you ever had undescended testicles? Y / N Have you been circumcised? Y / N

Do you regularly exam your testicles for lumps or swelling? Y / N

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

Do you have a history of sexual abuse? Y / N

Do you now or have you in the past had any communicable diseases? *(Ex: syphilis, hepatitis B, HIV, gonorrhea)* Y / N

If yes, please list: _____

WOMEN ONLY:

Date of your last menstrual cycle: _____ Regular? _____ Irregular? _____ Age at onset of menses? _____

Date of your last pap smear: _____ Pelvic exam: _____ Self-breast exam: _____

Date of your last mammogram: _____ Any nipple discharge? Y / N

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

Have you ever been pregnant? Y / N How many live births? _____ Miscarriages? _____

Do you have a history of sexual abuse? Y / N

Do you now or have you in the past had any communicable diseases? *(Ex: syphilis, hepatitis B, HIV, gonorrhea)* Y / N

If yes, please list: _____

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 is collected 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 receive notification 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**

MERCER Medicine

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 hereby acknowledge and confirm that my signature below gives my informed consent to the provision of care, diagnosis and/or treatment provided by Mercer Medicine. I also acknowledge that I have the right to discontinue treatment/care and to change to a physician outside of Mercer Medicine, if I choose to do so.

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

_____ _____

Signature of Patient or Patient Representative *Date*

MERCER Medicine

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name:_____ Date of Birth:_____

Home/Cell Phone:_____ Social Security #:_____

Address:_____ City:_____ State:_____ Zip:_____

Health care provider or health care entity authorized to disclose this information:

Name:_____ Phone:_____ Fax:_____

Address:_____ City:_____ State:_____ Zip:_____

Person or entity authorized to receive this information:

Name:_____ Phone:_____ Fax:_____

Address:_____ City:_____ State:_____ Zip:_____

Specific information disclosed: ***(check one)***

☐ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes, test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.

☐ Other:_____

Include: ***(Indicate by Initialing)***

_____Drug, Alcohol or Substance Abuse Records

_____Mental Health Records

_____HIV/AIDS-Related Information (Including HIV/AIDS Test Results)

Reason for release of information:
(Choose all that apply)

☐ Treatment/Continuing Medical Care
☐ Personal Use
☐ Billing or Claims
☐ Insurance
☐ Legal Purposes
☐ Disability Determination
☐ School
☐ Employment
☐ Other *(Specify)*:_____

The individual signing this form agrees and acknowledges as follows:

(i) **Voluntary Authorization:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

(ii) **Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

(iii) **Special Information:** This authorization may include disclosure of information relating to **DRUG, ALCOHOL** and **SUBSTANCE ABUSE**, **MENTAL HEALTH INFORMATION** and **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION** only if I place my initials on the appropriate lines above.

(iv) **Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

_____ _____

Signature of Patient/Legal Representative Date

If Legal Representative, relationship to Patient: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.