MARY ELIZABETH WILES DO PC • 374A PAT HARALSON DR, BLAIRSVILLE GA 30512-8409

BLAIRSVILLE
INTERNAL MEDICINE

Annual Patient Agreement

Thank you for choosing Blairsville Internal Medicine for your healthcare provider. We feel honored you have chosen our practice and would like to educate you on how our practice may differ from your previous primary care providers. Our primary concern is to take excellent care of our patients while following up to date guidelines for control of disease processes, coordinating care with other providers, ensuring annual wellness and preventative care is addressed and completed and providing timely follow up with your primary care provider. Given our focus on prevention and well controlled chronic diseases, our expectation is cooperation by the patient. We will work closely with each patient to explain the process and necessity when ordering, but we would like you to be familiar with these expectations prior to becoming a new patient as we want to ensure we are the right fit for your healthcare goals.

- Annual Physical (non-Medicare patients)
    - Including tobacco, obesity and depression screening per insurance guidelines
- Medicare Wellness (patients on Medicare and Medicare Advantage)
    - An office visit and a copay if applicable on all patients who have any medical conditions
    - Including tobacco, obesity, cardiovascular, memory, social determination of health and depression screening per insurance guidelines
    - Advanced Care Plan or POLST or Living Will (Please bring a copy of we do not already have one on file)
- Patients with chronic medical problems (Provider discretion) are usually seen every three months including Diabetics (A1C every three months), Hypertensive patients, etc.
- Seven-day follow up after hospitalization regardless of diagnosis. Please notify our office.
- Daily sick appointments are available but may not be with your normal clinical provider. We prefer our patients come to our office for sick visits, rather than going to a walk-in clinic. Please call or send a portal message as soon as you realize you are ill. Antibiotics are not called in without a patient being seen by a provider (in office or telemedicine).
- All specialist visit notes, tests and labs should be forwarded to our office.
- Colon screening: Colonoscopy every 10 years, or Cologuard every three years, or Fecal Occult Blood test annually
- Mammogram (females): Annually or Biannually age 50-74
- Bone Density (females): Every two yrs after age 65
- Cervical Cancer Screening (females): Until 30 yrs of age - every three years; for 30-64 yrs of age, every five years if performed with HPV screening, otherwise every three years.
- PSA (males): Annually per discussion with the patient.
- Annual labs with Cholesterol screening.
- Annual Chest Xray or CT scan in a person who smoked more than 20 pack years.
- Annual Flu vaccine (beginning as early as August, preferably before November).
- Current vaccines per CDC recommendation including Pneumonia, Shingles, Tetanus, COVID, RSV.
- **All No Shows for office visits will be charged: Follow-up/sick visits: $50; New Patient/Physicals: $75; Medical Wellness: $100.**

Please initial here that you accept all of the above requirements:_____

If the above are completed at another provider's office, we will need to obtain documentation of that for our charts. Please complete a release of records so that we may obtain this information. In preparation for your visit, we have included a packet of information that we are requesting you fill out and return to our office using one of the following methods:

1. Drop the paperwork off at our office front desk
2. Mail to: PO Box 1000 Blairsville GA 30512
3. Fax to 1-706-745-0282

Please return all paperwork as soon as you have it completed prior to your appointment. We need your fully completed paperwork to schedule your appointment. We also appreciate receiving your previous health record prior to your arrival. If you have any questions about the following forms, please do not hesitate to call our office for further assistance.

When you return with your paperwork, we will be taking your photograph for our electronic medical chart and scanning your driving license and your insurance card(s).

- New Patients: contact your insurance company to elect your new provider or their supervising physician as PCP.
- Existing patients: verify your provider or their supervising physician is listed as your PCP on your insurance card. *(Front desk staff can help you with this if you need help.)*

On the day of your appointments, we ask that you arrive a few minutes prior to your scheduled visit time.
Please bring the following to every patient visit:
Your driver's license (or photo id) and insurance card
All medications you are taking. *This includes prescriptions, supplements, creams, and over the counter. This is to ensure that your medication list is accurate and allows the nurses to check your prescription bottles for necessary refills at the time of the visit.*

While we are happy to provide your care for your medical problems, **we do not prescribe controlled substances, including narcotics or benzodiazepines.** It will be the responsibility of the patient or their family to locate a chronic pain specialist or psychiatrist to prescribe these medications. We will provide you with a list of local specialists if needed. We will not be responsible for prescribing these medications during your transition to a specialist or if you run out of these medications or are unable to get in touch with your specialist.

We look forward to meeting with you in person and forming a long-lasting healthcare partnership. By signing below you agree to participate with all the preventive health measures described above; failure to do so may result in your discharge from this practice.

Sincerely,

Your Blairsville Internal Medicine Providers.

_____ _____

Signature of patient acknowledging receipt of above Date

Blairsville Internal Medicine

374A Pat Haralson Drive PO Box 1000 Blairsville, GA 30514 706-745-5541 FAX 706-745-0282

AUTHORIZATION FOR BIM TO RELEASE MEDICAL INFORMATION

PATIENT _____ DATE OF BIRTH _____ CHART _____

I hereby authorize use and/or disclosure of protected health information (PHI) about me as described below. By signing, I authorize **Blairsville Internal Medicine** to disclose certain PHI about me to:

NAME _____

ADDRESS _____

CITY STATE ZIP _____

Phone #: _____ FAX #: _____

The specific information to be disclosed is:

_____The contents of my medical file, specifically: the most recent office notes, laboratory data, problem list, medication list, procedure reports, x-rays or medical records which may have been obtained from another source. I acknowledge that the information I am requesting may contain information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information.

_____Other (please specify): _____

The information will be used or disclosed for the following purpose:

_____To aid in the diagnosis and/or continuing treatment of the patient.

_____Other (please specify): _____

Blairsville Internal Medicine will _____ will not _____ receive payment for the authorized copies.

This authorization expires one year from the date I enter below, or by notifying the releasing organization in writing of my desire to revoke (cancel) it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign it.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

_____ _____

SIGNATURE of Patient, Legal Guardian or Healthcare Proxy DATE

_____ DOB _____ SSN _____

Printed Name of Legal Guardian or Healthcare Proxy

Patient/Guardian must be provided with a signed copy of this authorization form.

References to "the practice(s)" in this document include Mary Beth Wiles, MD, PC; Mary Elizabeth Wiles, DO, PC; and Blairsville Internal Medicine and all its providers.
10/17/2014; rev 07/2015; rev 11/2017; rev 08/2018; rev 07/2019

Blairsville Internal Medicine

Patient Name _____ DOB _____ CHART _____

Authorize Records Release from Another Provider

I hereby authorize release/disclosure of protected health information (PHI) about me as described below. By signing, I

authorize _____(Provider/PracticeName)

_____(Address, City, Zip)

_____(Phone and Fax)

to disclose PHI about me to

Blairsville Internal Medicine Mail to: PO Box 1000 Blairsville, GA 30514
FAX TO: 706-745-0282

The information to be disclosed is:

_____ The contents of my medical file, specifically: 1) the problem list, medication list, and most recent office notes; and 2) laboratory data, procedure reports, x-rays or tests results obtained within the last year.

_____ Other (please specify): _____

The information will be used or disclosed for the following purpose:

_____ To aid in the diagnosis and/or continuing treatment of me as a patient.

_____ Other (please specify): _____

I understand that this disclosure may include information regarding alcohol and drug abuse/treatment, psychological and social work counseling, HIV or AIDS or ARC, communicable disease or infections, including sexually transmitted diseases, venereal disease, tuberculosis and hepatitis, and demographic information.

This authorization expires one year from the date I enter below, or by notifying the releasing organization in writing of my desire to revoke (cancel) it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign it.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

_____ _____
SIGNATURE of Patient, Legal Guardian or Healthcare Proxy DATE

_____DOB _____SSN _____
Printed Name of Legal Guardian or Healthcare Proxy

Patient/Guardian must be provided with a signed copy of this authorization form.

Blairsville Internal Medicine

Patient _____ DOB _____ Chart _____

Consent to Obtain Patient Medication History

Our office would like to include your medication history in your medical record. A medication history is a list of prescription medicines that we or other doctors have prescribed for you and is collected from several sources, including your pharmacy and health insurance.

An accurate medication history is very important to help us treat you and to avoid potentially dangerous drug interactions. By signing this consent form you give us permission to collect, and give your pharmacy, your Pharmacy Benefit Manager and your health insurance permission to give us information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression. This information will become part of your electronic medical record, should your provider feel it is important to your medical care.

This medication history is a useful guide, but it may not be complete. Some pharmacies do not make drug history available to us, and the drug history might not include drugs that you purchased without using your health insurance. Your medication history might not include over the counter medicines, supplements or herbal remedies. It is still very important for us to take the time to discuss everything you are taking, and for you to tell us about any errors in your medication history.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

Consent to Share Patient Information with HIE

An Electronic health information exchange (HIE) allows doctors, nurses, pharmacists, other health care providers and patients to appropriately access and securely share a patient's vital medical information electronically—improving the speed, quality, safety and cost of patient care. Our office submits data to the GaHIN, which is a nonprofit health information exchange (HIE) that facilitates the use and secure exchange of patient health information so providers have the information they need at the point of care. The Continuity of Care Information on the HIE is secure and may only be accessed by providers who participate with the HIE, like your hospital, your pharmacy, and your other healthcare providers. Only providers who are directly involved in your care are allowed by the HIE to access your information. Having necessary information like your allergies, medical conditions or prescriptions medications may prove life-saving in emergencies, as well as convenient for referrals. To opt-out of HIE, please speak with personnel at Registration.

I give my permission to share Continuity of Care Information on the Health Information Exchange (HIE).

_____ _____

SIGNATURE of Patient, Legal Guardian or Healthcare Proxy DATE

_____ DOB _____ SSN _____

Printed Name of Legal Guardian or Healthcare Proxy

374A Pat Haralson Drive PO Box 1000 Blairsville, GA 30514 706-745-5541 fax 706-745-0282

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Rev 07/204: rrev 11/2017, rev 08/2018, rev 07/2019, 4/2023

Blairsville Internal Medicine

Patient _____ DOB _____ Chart _____

Financial Policies

Our healthcare providers, employees and agents strive to provide you with the highest quality medical care. The bills for charges resulting from professional services provided by the practices named below are the responsibility of the patient or his/her guarantor.

If you have medical insurance, your insurance is a contract between you and the insurance company. We are members of most major insurance networks and will file insurance claims for you if you have made an assignment of benefits to us. Not all services are a covered benefit in all contracts. Any charges that are allowed by your insurance company but are denied or not paid by them are your responsibility. We are legally required to collect co-payments on the day the services are provided. If a statement is sent, a $15.00 fee will be added.

If you do not have insurance, payment for services, billed according to our current fee schedule, is due at the time services are rendered. **If you wish to establish a time payment plan, you must arrange it prior to seeing the doctor.**
Regular monthly payments are required and are due by the 15th day of each month.

A $30.00 fee will be charged for returned checks and you will be required to pay by cash or credit/debit card in the future. Past due accounts will be charged interest at the legal rate.

If Prior Authorization of prescriptions is required by your insurance or Pharmacy Benefit Manager, a $20.00 fee will be billed to your account.

Charges will be applied for missed appointments and appointments cancelled without 24 hours advance notice. A $25.00 fee will be charged for each missed or un-cancelled office appointment. Any patient that misses or fails to cancel three (3) scheduled office appointments may be given a 30-day notice to find another healthcare provider and dismissed from this practice. Failure to keep the Initial Visit will result in a $50.00 charge. If you are scheduled with one of our providers for a Hospital procedure, like a colonoscopy, and miss the appointment or fail to cancel with this office 24 hours in advance, you will be charged a $50.00 Missed Appointment Fee. For missed or un-canceled scans scheduled in our office, the fee will be $100.00 or our cost, whichever is greater.

We want you to receive the medical care you need. If you are having trouble paying your bill, please call our office. We may be able to arrange a payment plan or provide information for community help. If your account goes 90 days without payment, it may be referred to a collection agency and you will be discharged from the practices. Should your account be referred to a collection agency, collection fees, late charges and/or attorney charges may be added to your balance. Patients discharged from the practice are not accepted back.

1. **FINANCIAL AGREEMENT:** I acknowledge and agree that I am responsible for all charges for services provided to me which are not covered by my insurance plan(s) or for which I am responsible under my plan(s). To the extent no coverage exists under my plan, or I have no insurance coverage, I acknowledge that I am responsible for all charges for services provided and agree to pay those charges.

2. **ASSIGNMENT OF BENEFITS AND PAYMENT REQUEST:** I assign to the Practices named below all of my rights and benefits that I have in any medical insurance plan, health benefit plan, indemnity plan, trust, fund or other source of payment for healthcare services in connection with medical services provided by the Practices, employees and agents. I understand that this document is a direct assignment of my rights and benefits under my plan. I instruct my insurance company to pay the Practices directly for the professional or medical expense benefits payable to me

3. **AUTHORIZATION FOR RELEASE OF INFORMATION AND CLAIM AUTHORIZATION:** I authorize Provider and/or its agents to release any medical or other information about me in its possession to my insurance plan, the Social Security Administration, any state agency, or their intermediaries or fiscal agents required or requested in connection with any claim for services rendered to me by the providers at the Practices named below.

A photocopy of this Assignment shall be considered as effective and valid as the original.

_____ _____
SIGNATURE of Patient or Responsible Party (Guarantor) DATE

_____ DOB _____ SSN _____
Printed Name of Responsible Party (Guarantor)

Address _____ Phone _____

Blairsville Internal Medicine Health History Questionnaire

Your answers will help your health care provider better understand your medical concerns and conditions. If you cannot remember specific details, please approximate. Add any notes you think are important. INFORMATION IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL.

Patient Name _____ **Date of Birth** _____

Main reason for today's visit _____

Other concerns _____

REVIEW OF SYSTEMS Please check all that apply:

Constitutional ☐ Exercise Intolerance ☐ Fatigue ☐ Fever ☐ Weight Gain (____lbs) ☐ Weight Loss (____lbs) ☐ Other _____

Eyes ☐ Dry Eyes ☐ Irritation ☐ Vision Change Date of Last Exam:_____ ☐ Other _____

Ears/Nose/Mouth/Throat ☐ Bleeding Gums ☐ Difficulty Hearing ☐ Dizziness ☐ Dry Mouth ☐ Ear Pain ☐ Frequent Infections
☐ Frequent Nosebleeds ☐ Hoarseness ☐ Mouth Breathing ☐ Mouth Ulcers ☐ Nose/Sinus Problems ☐ Ringing in Ears
☐ Other _____

Cardiovascular ☐ Arm Pain on Exertion ☐ Chest Pain on Exertion ☐ Chest Heaviness/Pressure on Exertion ☐ Irregular Heart Beats (Palpitations)
☐ Known Heart Murmur ☐ Light-headed on Standing ☐ Shortness of Breath When Lying Down ☐ Shortness of Breath When Walking
☐ Swelling (edema) ☐ Other _____

Respiratory ☐ Cough ☐ Coughing Up Blood ☐ Shortness of Breath ☐ Sleep Apnea ☐ Snoring ☐ Wheezing ☐ Other _____

Gastrointestinal ☐ Abdominal Pain ☐ Black or Tarry Stool ☐ Blood in Stool ☐ Change in Appetite ☐ Frequent Indigestion ☐ Hemorrhoids
☐ Trouble Swallowing ☐ Vomiting ☐ Vomiting Blood ☐ Other _____

Genitourinary ☐ Blood in Urine ☐ Difficulty Urinating ☐ Incomplete Emptying ☐ Increased Urinary Frequency ☐ Urinary Loss of Control
☐ Wake in the night to go to the bathroom ☐ Other _____

Female: ☐ Bleeding between periods ☐ Heavy periods ☐ Extreme menstrual pain ☐ Vaginal itching, burning, or discharge
☐ Hot flashes ☐ Breast lump or nipple discharge ☐ Painful intercourse ☐ Other _____

Musculoskeletal ☐ Back Pain ☐ Joint Pain ☐ Muscle Aches ☐ Muscle Weakness ☐ Other _____

Integumentary (Skin) ☐ Changes in Moles ☐ Dry Skin ☐ Eczema ☐ Growth/Lesions ☐ Itching ☐ Jaundice (Yellow Skin/Eyes)
☐ Rash ☐ Other _____

Neurological ☐ Dizziness ☐ Fainting ☐ Headaches ☐ Memory Loss ☐ Migraines ☐ Numbness ☐ Restless Legs ☐ Seizures ☐ Weakness
☐ Other _____

Psychiatric ☐ Alcohol Overuse ☐ Anxiety/Stress ☐ Depression ☐ Do Not Feel Safe in Relationship ☐ Mania ☐ Sleep Problems
☐ Other _____

Endocrine ☐ Fatigue ☐ Increased Thirst/Hunger/Urination ☐ Other _____

Hematologic/Lymphatic ☐ Easy Bruising/Bleeding ☐ Swollen Glands ☐ Other _____

Allergic/Immunologic ☐ Frequent Sneezing ☐ Hives ☐ Itching ☐ Runny Nose ☐ Sinus Pressure ☐ Other _____

PAST MEDICAL HISTORY Please check all that apply:

☐ Anemia
☐ Anxiety / Depression
☐ Arthritis
☐ Asthma
☐ Bleeding Disorder
☐ Blood Clots / DVT / Pulmonary Embolism
☐ Cancer type
☐ COPD
☐ Coronary Artery Disease
☐ Alzheimer's / Dementia
☐ Diabetes - Insulin
☐ Diabetes - Non-Insulin
☐ Other _____
☐ Dialysis
☐ Diverticulitis
☐ Fibromyalgia
☐ Gout
☐ Heart Attack
☐ Heart Murmur
☐ GERD (acid reflux) / Hiatal Hernia
☐ HIV or AIDS
☐ High Cholesterol
☐ High Blood Pressure
☐ Insomnia
☐ Kidney Disease
☐ Kidney Stones
☐ Leg/Foot Ulcers
☐ Liver Disease
☐ Migraine
☐ Osteoporosis
☐ Pacemaker
☐ Pre-Diabetes
☐ Seizures
☐ Sleep Apnea
☐ Stroke
☐ Thyroid ☐ Overactive ☐ Underactive

(Women Only) OBSTETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear Date _____ ☐ Abnormal ☐ Declined ☐ Not Done
Last Mammogram Date _____ ☐ Abnormal ☐ Declined ☐ Not Done
Age of first menstrual period _____ Date of last menstrual period or age of menopause _____
Number of pregnancies _____ Births _____ ☐ Cesarean sections If yes, then number _____
Miscarriages _____ Abortions _____

PAST SURGICAL HISTORY and PAST HOSPITALIZATION(S)

1. _____ Reason _____ Year_____ Hospital _____
2. _____ Reason _____ Year_____ Hospital _____
3. _____ Reason _____ Year_____ Hospital _____
4. _____ Reason _____ Year_____ Hospital _____
5. _____ Reason _____ Year_____ Hospital _____

SOCIAL HISTORY

Occupation _____ Currently employed? ☐ Yes ☐ No ☐ Retired ☐ On disability (reason) _____

Education ☐ Less than 8th grade ☐ High school ☐ 2 year college ☐ 4 year college ☐ Post graduate
Any barriers to learning? ☐ Vision ☐ Hearing ☐ Unable to Read ☐ Other _____
Primary Language _____ Do you need an interpreter? ☐ Yes ☐ No

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic partner

Diet ☐ Regular ☐ Vegetarian/Vegan ☐ Diabetic ☐ Cardiac ☐ Gluten Free ☐ Other _____

Exercise Type _____ Frequency _____ Duration _____ (mins)

Caffeine ☐ None ☐ Occasional ☐ Moderate ☐ Heavy Number of cups/cans per day? _____

Alcohol Do you drink alcohol? ☐ Yes ☐ No Do you have a history of ☐ Alcohol Abuse ☐ Alcoholism
How often do you consume alcohol? ☐ Occasionally ☐ < 3 times a week ☐ > 3 times a week How many drinks per week? _____
How many days in the past year have you had heavy drinking consumption (4+ female, 5+ male)? _____

Tobacco Do you use tobacco? ☐ Yes ☐ # of years_____ ☐ No Or year quit _____
If not currently, did you ever use tobacco? ☐ Yes ☐ No
☐ Cigarettes - _____pks./day ☐ Cigars - _____/day ☐ Vape - _____/day ☐ Chew - _____/day

Drugs Do you currently use recreational or street drugs? ☐ Yes ☐ No
If yes, list: _____

Sexual Activity Are you currently sexually active? ☐ Yes ☐ No, not active since _____
Current or past sexual partner(s) include ☐ Female ☐ Male ☐ Female and Male
Do you have a history of physical, sexual or emotional abuse? ☐ Yes ☐ No
Do you use condoms? ☐ Yes ☐ No Other Birth control method used: _____
Are you interested in being screened for Sexually Transmitted Diseases (STDs)? ☐ Yes ☐ No
Have you been screened for Hepatitis C? ☐ Yes ☐ No Date _____

Housing Do you live ☐ at home, alone ☐ at home with spouse or other family ☐ in Assisted Living Facility
Do you feel safe at home? ☐ Yes ☐ No Reason _____

FAMILY HEALTH HISTORY

Grandmother (maternal)	Alive Y / N Age _____	☐ Cancer (type) _____ ☐ Diabetes ☐ Heart disease / Stroke ☐ Hypertension ☐ Other _____
Grandfather (maternal)	Alive Y / N Age _____	☐ Cancer (type) _____ ☐ Diabetes ☐ Heart disease / Stroke ☐ Hypertension ☐ Other _____
Grandmother (paternal)	Alive Y / N Age _____	☐ Cancer (type) _____ ☐ Diabetes ☐ Heart disease / Stroke ☐ Hypertension ☐ Other _____
Grandfather (paternal)	Alive Y / N Age _____	☐ Cancer (type) _____ ☐ Diabetes ☐ Heart disease / Stroke ☐ Hypertension ☐ Other _____
Father	Alive Y / N Age _____	☐ Cancer (type) _____ ☐ Diabetes ☐ Heart disease / Stroke ☐ Hypertension ☐ Other _____

Mother Alive Y / N Age _____ ☐ Cancer (type) _____ ☐ Diabetes ☐ Heart disease / Stroke ☐ Hypertension ☐ Other _____

Brother/Sister Alive Y / N Age _____ ☐ Cancer (type) _____ ☐ Diabetes ☐ Heart disease / Stroke ☐ Hypertension ☐ Other _____

Brother/Sister Alive Y / N Age _____ ☐ Cancer (type) _____ ☐ Diabetes ☐ Heart disease / Stroke ☐ Hypertension ☐ Other _____

Other _____ Alive Y / N Age _____ ☐ Cancer (type) _____ ☐ Diabetes ☐ Heart disease / Stroke ☐ Hypertension ☐ Other _____

MEDICATIONS Check Primary Pharmacy ☐ Local _____ (city) _____ ☐ Mail-order _____

Please list all your medications; include prescriptions, over-the-counter drugs, vitamins, inhalers, diabetic test strips, etc.

1. _____ Strength _____ Frequency _____
2. _____ Strength _____ Frequency _____
3. _____ Strength _____ Frequency _____
4. _____ Strength _____ Frequency _____
5. _____ Strength _____ Frequency _____
6. _____ Strength _____ Frequency _____
7. _____ Strength _____ Frequency _____
8. _____ Strength _____ Frequency _____
9. _____ Strength _____ Frequency _____
10. _____ Strength _____ Frequency _____
11. _____ Strength _____ Frequency _____
12. _____ Strength _____ Frequency _____
13. _____ Strength _____ Frequency _____
14. _____ Strength _____ Frequency _____
15. _____ Strength _____ Frequency _____
16. _____ Strength _____ Frequency _____
17. _____ Strength _____ Frequency _____
18. _____ Strength _____ Frequency _____

ALLERGIES: List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

1. _____ Reaction _____
2. _____ Reaction _____
3. _____ Reaction _____

IMMUNIZATION HISTORY Please give most recent date of administration or indicate if vaccination was Declined.

☐ Chickenpox Date _____ ☐ Declined
☐ Flu Shot Date _____ ☐ Declined
☐ Gardasil/HPV Date _____ ☐ Declined
☐ Hepatitis A Date _____ ☐ Declined
☐ Hepatitis B Date _____ ☐ Declined
☐ Meningococcus Date _____ ☐ Declined
☐ MMR *(Measles, Mumps, Rubella)* Date _____ ☐ Declined
☐ Pneumonia ☐ Pneumovax 23 Date _____ ☐ Declined ☐ Prevnar 13 Date _____ ☐ Declined
Prevnar 20 Date _____ ☐ Declined
☐ Covid Shot Brand _____ 1st Date _____ ☐ Declined 2nd Date _____ ☐ Declined
Covid Booster Date _____ ☐ Declined
☐ Shingles ☐ Zostavax Date _____ ☐ Declined ☐ Shingrix Date(s) _____ ☐ Declined
☐ Tdap *(Tetanus and pertussis)* Date _____ ☐ Declined

☐ I choose NOT to take vaccinations.

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Original 12/12/2018; rev 07/2019. 4/2023

HEALTH MAINTENANCE

Advance Directive / Living Will / POLST ☐ Yes, please bring copy to include in your medical record. ☐ No

Medical Power of Attorney? ☐ Yes ☐ No Name _____ Phone _____

Code Status ☐ Full (CPR, intubation & mechanical ventilation, cardioversion) ☐ Do Not Resuscitate ☐ Other _____

Blood transfusion okay in an emergency? ☐ Yes ☐ No Dialysis okay? ☐ Yes ☐ No

Annual Physical ☐ Yes Date _____ ☐ No Medicare Wellness Exam ☐ Yes Date _____ ☐ No ☐ Declined

Colon Cancer Screening Colonoscopy ☐ Yes Results _____ Date _____ repeat due _____ ☐ No ☐ Declined

Cologuard ☐ Yes Date _____ ☐ No ☐ Declined Fecal Occult Blood Test (card) ☐ Yes Date _____ ☐ No ☐ Declined

Have you ever had a bone density screening? ☐ Yes Results _____ Date _____ ☐ No ☐ Declined

Have you ever had an Aortic Aneurysm Screening (Ultrasound)? ☐ Yes Results _____ Date _____ ☐ No ☐ Declined

Are you diagnosed as ☐ Pre-diabetic (borderline) or ☐ Diabetic? If so, please answer the following.

Last A1C result _____ Date _____ Last Microalbumin result _____ Date _____

Last Diabetic Foot Exam Date _____ Last Dilated Eye Exam Date _____ Results_____ By _____

Last LDL Cholesterol result _____ Date _____ Are you currently taking a statin drug? ☐ Yes ☐ No ☐ Declined

Have you had reaction to a statin drug? ☐ Yes ☐ No Name(s) _____ Reaction _____

If you are diagnosed with Hypertension, please list Blood Pressure readings for last 10 days:

1. Date _____ Time _____ AM / PM Reading _____ / _____
2. Date _____ Time _____ AM / PM Reading _____ / _____
3. Date _____ Time _____ AM / PM Reading _____ / _____
4. Date _____ Time _____ AM / PM Reading _____ / _____
5. Date _____ Time _____ AM / PM Reading _____ / _____
6. Date _____ Time _____ AM / PM Reading _____ / _____
7. Date _____ Time _____ AM / PM Reading _____ / _____
8. Date _____ Time _____ AM / PM Reading _____ / _____
9. Date _____ Time _____ AM / PM Reading _____ / _____
10. Date _____ Time _____ AM / PM Reading _____ / _____

If you have a copy of lab results, please provide for your medical record. If not, please contact last doctor and ask results be sent to our office. If you routinely see another doctor who performs lab tests, please be sure they forward copies of current and future results. Appointments WILL NOT be scheduled until after results are received.

Previous Primary Care Provider _____ Specialty _____ Phone _____

Reason for changing provider _____

Specialist Provider(s). Name _____ Specialty _____ Phone _____

Name _____ Specialty _____ Phone _____

Name _____ Specialty _____ Phone _____

Name _____ Specialty _____ Phone _____

Name _____ Specialty _____ Phone _____

The information above is accurate, to the best of my knowledge.

Printed Name of Patient _____ Date of Birth _____

Printed Name of Guardian _____ Telephone _____

Guardian is ☐ Spouse ☐ Parent ☐ Other family _____ ☐ Caregiver ☐ has Power of Attorney (please, provide copy)

_____ Date Signed

Signature of Patient, Guardian or Legal Representative

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Original 12/12/2018; rev 07/2019. 4/2023

Please review and update the information below to the best of your ability.

Patient Registration

CURRENT PATIENT INFORMATION -- PLEASE PRINT

Last Name:
First Name:
Middle Name:
Address:
City:
Zip:
Home Phone:
Work Phone:
Mobile Phone:
Sex:
Date of Birth:
Social Security No.
Patient email:

Guarantor Information (to whom statements are sent)

Name:
Address:

Relationship to patient: _____
Date of Birth:
Social Security No.:
Phone: ( ) _____ - _____

Emergency Contact Information

Name:
Relationship:
Phone: ( )
Mobile Phone:( ) _____ - _____

Primary Insurance Information

Insurance Plan Name:

Policy Holder (if other than patient)

Last Name:
First Name:
Middle Name:
Address:
City: State: Zip:
Date of Birth: Sex (please circle): **M** or **F**
Employer Name:

Policy Information

Patient's relationship to policy holder:
ID/Certification No.:
Policy/Group No.:

Secondary Insurance Information

Insurance Plan Name:

Policy Holder (if other than patient)

Last Name:
First Name:
Middle Name:
Address:
City: State: Zip:
Date of Birth:, Sex (please circle): **M** or **F**
Employer Name:

Policy Information

Patient's relationship to policy holder:
ID/Certification No.:
Policy/Group No.:

ASSIGNMENT AND RELEASE:

- **I hereby assign my insurance benefits to be paid directly to the physician.**
- **I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.**
- **I authorize the physician to release any medical information required to process this claim.**
- **I authorize my provider's office to contact me by telephone to remind me of my appointments.**
- **A fee for no shows may apply.**

Signed_____ **Date:**_____

Blairsville Internal Medicine

Patient _____ DOB _____ Chart _____

Privacy Practices Acknowledgement

I acknowledge that I have been made aware of the **Notice of Privacy Practices** for the Practices named below and that I have a right to receive a copy upon request. This **Notice** describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of the Practices' health care operations. The **Notice** also describes my rights and the duties of the Practices with respect to my protected health information. I understand that copies of the **Notice of Privacy Practices** are available in the Practices' registration area and on the Practices' web site. I may request that a copy be mailed to me by writing: Privacy Officer, PO Box 1000, Blairsville, GA 30514.

_____ _____

Signature of Patient, Legal Guardian or Health Care Proxy Date

How are we authorized to contact you?

Please check all that apply. At least one call method must be selected.

___ You may call my **HOME PHONE** ___ Leave call back number only Okay to leave message	___ You may call my **CELL PHONE** ___ Leave call back number only Okay to leave message	___ You may call my **WORK PHONE** ___ Leave call back number only Okay to leave message

Choose how you wish to be contacted.

Notifications (labs, etc)	☐ Email* _____	☐ Text*	☐ Phone, as shown above
Appointments	☐ Email* _____	☐ Text*	☐ Phone, as shown above
Announcements	☐ Email* _____	☐ Text*	☐ Phone, as shown above
Billing	☐ Email* _____	☐ Text*	☐ Phone, as shown above

***Requires Portal registration. Please see Check In person, call 706-745-5541**

Is there someone you wish to name that you consent to receive medical and billing information about you?
☐ No, only me. Information about my treatment, medication, billing, etc. will be disclosed to ONLY me.
☐ Spouse/Partner ☐ I consent for Spouse/Partner to have Portal access. Please send invitation to his/her email

Email _____

☐ If other than Spouse/Partner, please complete the following:

Name _____ Relationship _____ Phone (_____)_____

☐ Consent for Portal access. Email _____

Name _____ Relationship _____ Phone (_____)_____

☐ Consent for Portal access. Email _____

I give my consent to be contacted in the manner(s) I have chosen above. If I have chosen my spouse or other person(s) to receive information on my behalf, I give my consent for them to receive information about me. If at any time I wish to change the manner by which I am contacted or the person(s) with whom you may share information, I am aware that I must notify the Practices in writing by completing a new consent form. This consent is valid until I provide the Practices a completed and signed new consent form.

_____ _____

Signature of Patient, Legal Guardian or Health Care Proxy Date

Blairsville Internal Medicine

NAME: _____ Date: _____

Prospective New Patient,

In order for us to schedule your first appointment with one of our providers, we will need to request all of your medical records from your previous doctors including for example: primary doctor (PCP), eye doctor, cardiologist, dermatologist. Please create a list of your previous providers below including their name, field of practice (for example: cardiologist), name of practice, street address and phone number.

Doctor's name: _____

Field of Practice: _____

Name of Practice: _____

Street Address: _____

Phone: _____

Doctor's name: _____

Field of Practice: _____

Name of Practice: _____

Street Address: _____

Phone: _____

Doctor's name: _____

Field of Practice: _____

Name of Practice: _____

Street Address: _____

Phone: _____

Doctor's name: _____

Field of Practice: _____

Name of Practice: _____

Street Address: _____

Phone: _____

Doctor's name: _____

Field of Practice: _____

Name of Practice: _____

Street Address: _____

Phone: _____

Doctor's name: _____

Field of Practice: _____

Name of Practice: _____

Street Address: _____

Phone: _____

Doctor's name: _____

Field of Practice: _____

Name of Practice: _____

Street Address: _____

Phone: _____