

PATIENT REGISTRATION FORM

Date:		Reason for Visit:					
LAST NAME			FIRST NAME			MIDDLE NAME	
SOCIAL SECURITY #			SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	IDENTIFY MYSELF AS: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____		BIRTH DATE (mm/dd/yyyy)	
MAILING ADDRESS			CITY		STATE		ZIP
HOME PHONE		WORK PHONE		MOBILE PHONE		E-MAIL ADDRESS	
MARITAL STATUS <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W		INTERPRETER NEEDED? <input type="checkbox"/> Yes <input type="checkbox"/> No	PREFERRED LANGUAGE		RACE <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Other		ETHNICITY <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
RELIGION		COMMUNICATION PREFERENCE <input type="checkbox"/> Mail <input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Patient Portal			PRIMARY CARE PHYSICIAN		
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)							
<input type="checkbox"/> Auto/MVC	<input type="checkbox"/> Worker's Comp		<input type="checkbox"/> 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.							

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, John Doe, Partner)

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.

Patient Signature: _____ Date: _____

Guarantor Signature: _____ Relationship: _____

Print Name of Signature: _____ Email address: _____

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/GHI 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. 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 a credit card or by check (depending on the method of payment for the time of service deposit). If you are not able to make the minimum payment at check-in, you will be asked to reschedule your appointment unless you have an urgent need to be seen.
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.

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 _____

Date of Birth _____

Patient Signature _____

Date: _____

Parent/Legal Representative Signature: _____

Date: _____

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

CONTROLLED SUBSTANCE AGREEMENT

PAGE 1 OF 2

Patient Name: _____ Birth Date: _____ Chart # _____

My provider 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, opioids, sedatives, muscle relaxants, stimulants, benzodiazepines, 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 provider's guidance and participate in any treatment programs recommended, which could include discontinuation of a prescribed controlled substance, referral to a substance abuse treatment program or facility, psychological counseling, and/or medical treatment.

I agree to always be truthful with all my providers 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 due to the possibility of increased side effects.

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 due to the nature of side effects of this medication it can alter/impair cognitive function and operating.

I understand the increased risk of respiratory depression and death with high doses of controlled substances or use of multiple controlled substances (including combination therapy with benzodiazepines and opioids)

I understand the increased risk of drug overdose and death with the use of controlled substances.

I Agree To Abide By The Following Conditions:

- a. I will follow the treatment plan that my provider and I have agreed to.
- b. I will report any suspected side effects to my provider immediately.
- c. I understand that my provider is not obligated, nor will he/she automatically refill prescriptions for controlled medications that I have been receiving from another provider.
- d. I will not ask for nor accept controlled substance medications or prescriptions from any other individuals or providers while I am receiving such medication from this provider's office, this includes prescriptions for dental procedures and post-operative pain control. 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 provider.
- 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 provider 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 provider's supervision.
- j. I understand my provider may prescribe Narcan for home use in case overdose symptoms are present

...CONTINUED ON PAGE 2



CONTROLLED SUBSTANCE AGREEMENT

PAGE 2 OF 2

I Agree To Abide By The Following Conditions:

k. 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.

l. 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 provider.

m. I understand that rules, as issued by the Georgia State Board of Medical Examiners, may require that I see my prescribing provider at least every 3 months, or more frequently if mandated by the treating provider, to assess my condition and compliance with a 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, which will then need to be reviewed and may or may not be approved by the prescribing provider.

n. I authorize my provider 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 diversions of my controlled medications. I authorize my provider 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 provider if requested. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

o. 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.

p. 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 provider. They will not be refilled by other providers in the office, by phone, after hours, on weekends, or on holidays.

q. 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 provider 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

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. _____	_____	_____	_____

Living arrangements (please check)

- Patient lives at home
- Patient lives at a boarding or military school
- Patient lives in a foster home
- Patient lives in group home
- Other: _____

Primary Care Doctor

Name of Practice & Provider _____



Medical/Psychiatric History

Current Medical Illnesses: _____

Past Medical Illnesses: _____

Medication Allergies: _____

Food Allergies: _____

Current/Past Serious Injuries: _____

Current/Past Serious Head Trauma: _____

Surgeries: _____

Alcohol & Other Substance Abuse

Is the patient currently or have they previously used/abused alcohol on other illicit substances? If so, please explain and provide a brief history of these behaviors. _____

Habits

1. Does the patient use tobacco? Yes No If so, what type of tobacco use? _____
2. How many caffeinated drinks does the patient have per day? _____
3. How often does the patient exercise per week? _____



Northeast Georgia
PHYSICIANS GROUP

NGPG Psychiatry
200 Wisteria Drive
Gainesville, GA 30501
770-219-5407 • Fax 770-219-7192

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...)



CURRENT MEDICATIONS

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

MEDICATION NAME AND STRENGTH	DATE STARTED	REASON FOR MEDICATION

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

IF YOU NEED MORE SPACE PLEASE USE THE BACK OF THIS FORM