Southside Medical Care

CORPORATE OFFICE
6325 SHANNON PARKWAY
UNION CITY, GEORGIA 30291
(770) 964-1400
FAX (770) 306-1343

Family Medicine Treatment in the Era of COVID-19

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to **COVID-19**, also known as **"Coronavirus,"** at any time or any place. Be assured that our practice has always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so.

Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store, or favorite restaurant. "Social Distancing" nationwide has reduced the transmission of the Coronavirus. Although we have taken measures to provide social distancing in our practice, due to the nature of the care and procedures we provide, it is not possible to maintain social distancing between the patient, doctor, physician assistant, nurse practioner, staff and sometimes other patients at all times.

Although exposure is unlikely, do you accept the risk and consent to treatment?

Yes _____ No _____

_____ _____

Patient Signature Date

_____ _____

Patient Printed Name Date of Birth

SOUTHSIDE MEDICAL CARE

PATIENT INFORMATION- PLEASE PRINT CLEARLY

Patient's Name:_____ SS#: _____ - _____- _____

Birth Date: ____/____/_____ Sex: M or F Age: _____ Marital Status:_____

Guardian's Name if Minor: _____

Street Address:_____ City:_____ State:_____ Zip Code:_____

Primary Phone: _____ Secondary Phone: _____

Email: _____

PHARMACY INFORMATION

Pharmacy Name: _____ Pharmacy Number: _____

Pharmacy Location:_____

INSURANCE INFORMATION

1. **Primary Insurance** _____
   Policy Holder's Name:_____ Relationship to Policy Holder:_____
   Policy Holder's Date of Birth: ____/____/_____ Policy Holder's SS#: _____ - _____- _____
   Policy #: _____ Group #: _____
2. **Secondary Insurance** _____
   Policy Holder's Name:_____ Relationship to Policy Holder:_____
   Policy Holder's Date of Birth: ____/____/_____ Policy Holder's SS#: _____ - _____- _____
   Policy #: _____ Group #: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone #:_____

ANY PERSON(S) SMC CAN RELEASE INFORMATION TO

Name: _____ Relationship: _____ Phone #:_____

Name: _____ Relationship: _____ Phone #:_____

___ DO NOT RELEASE MY INFORMATION TO ANYONE

MEDICAL CONSENT
ASSIGNMENT OF BENEFITS- RELEASE OF INFORMATION

I HEREBY, UNDERSIGNED AUTHORIZE THE PHYSICANS, PHYSICIAN ASSISTANTS AND/OR NURSE PRACTIONER AND STAFF AT SOUTHSIDE MEDICAL CARE TO PROVIDE MEDICAL CARE FOR THE ABOVE NAMED PATIENT. I ALSO, CONSENT TO THE RELEASE BY SOUTHSIDE MEDICAL CARE OF ANY AND ALL MEDICAL INFORMATION NECESSARY TO PROCESS ANY AND ALL INSURANCE CLAIMS ON MY BEHALF. I HEREBY WITH MY SIGNATURE ASSIGN AND AUTHORIZE MY INSURANCE CARRIER (S) TO MAKE PAYMENT DIRECTLY TO SOUTHSIDE MEDICAL CARE FOR ALL SERVICES RENDERED.

SIGNATURE OF PATIENT: _____ **DATE:** _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Southside Medical Care to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Southside Medical Care's Notice of Privacy Practices provides a more complete description of such uses and disclosure's.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Southside Medical Care reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to 6325 Shannon Parkway, Union City, GA 30291.

With this consent, Southside Medical Care may call my home or alternative location and leave a voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Southside Medical Care may email me and/or send mail to my home or alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Southside Medical Care restrict how it uses or disclosures my PHI to carry out TPO. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Southside Medical Care's use that disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Southside Medical Care may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Print Name of Patient or Legal Guardian

I wish to be contacted in the following manner (check all that apply)

___ **Home Phone** _____-_____-_____

___ Permission to leave message with detailed information

___ Permission to leave message with call-back number only

___ **Cell Phone** _____-_____-_____

___ Permission to leave message with detailed information

___ Permission to leave message with call-back number only

___ **Written Communication**

___ Permission to mail to my home

___ **Other** _____

_____

Signature of Patient or Legal Guardian

Date

Print Name of Patient or Legal Guardian

Date of Birth

FINANCIAL UNDERSTANDING

PAYMENT US EXPECTED AT THE TIME SERVICES ARE RENDERED

We accept cash, check, debit, Visa, Master Card, American Express and Discover Card

In order to honor insurance benefits, you must provide your current health insurance card each time you visit our office. If your insurance plan requires a Primary Care Physician, our Physician's name/Practice name must be listed on your insurance card. If we are not listed as your Primary Care Physician you may pay for services out of pocket or you may reschedule your appointment when you have chosen one of our Physician's/Medical Practice as your Primary Care Doctor. If you belong to a managed care insurance plan, all applicable fees are due at the time of service. Please refer to your co-pay schedule. If your insurance company has a deductible and you have not met the deductible you will be responsible for payment at the time of services are rendered. Our office submits the majority of claims electronically to your insurance company within 24 hours of your visit. Most insurance companies send payment to us within 23 business days. Your insurance company sends you an Explanation Of Benefits stating what your patient responsibility is for your claim. From the Explanation Of Benefits you know the exact amount you owe to Southside Medical Care and we ask that you remit payment when you receive this information from your insurance company. When you come to the office for your appointment and there is a balance on your account we require payment on that balance at the time of service. There will be a $35 fee for any check or draft dishonored by any financial institution. In the event of collection placement of my account I understand I will be charged a late fee of $25 in addition to the balance subject to the collection. I hereby with my signature, understand that I am ultimately responsible for payment in full of all services rendered in the event my insurance carrier and/or managed care plan denies payment in full or part of any services rendered, including but not limited to all co-payments, deductibles, non covered services and supplies obtained during the course of care.

We use the following outside facilities to assist in some of the lab tests that cannot be processed in our office are sent to Quest Diagnostics or Labcorp (depending on your insurance). These facilities bill your insurance company directly for their services.

Signature of Patient or Legal Guardian	*Print Name of Patient or Legal Guardian*	*Date*

PATIENT HISTORY

NAME: _____ **DOB:** ____-____-____ **DATE:** ____-____-____

LAST MAMMOGRAM: ____-____-____ LOCATION: _____

LAST COLONOSCOPY: ____-____-____ LOCATION: _____

DRUG ALLERGIES

__ NO KNOW ALLERGIES

CURRENT MEDICATION

__ NONE

FAMILY HISTORY

	FATHER	MOTHER	FATHERS PARENTS	MOTHERS PARENTS	SIBILINGS	CHILDREN
HEART DISEASE						
HIGH BLOOD PRESSURE						
STROKE						
CANCER (TYPE)						
GLAUCOMA						
DIABETES						
EPILEPSY						
BLEEDING DISORDER						
KIDNEY DISORDER						
THYROID DISORDER						
MENTAL ILLNESS						
OSTEOPOROSIS						

MEDICAL HISTORY

__ Headaches
__ Shortness of Breath
__ Heart Palpitations
__ Heart Murmur
__ Chest Pain
__ Dizziness
__ Peripheral/Vascular Disease
__ Allergies/Hay Fever
__ Bronchitis

__ Pneumonia
__ Ulcer
__ GI Disorder
__ Lactose Intolerance
__ Gallbladder Disease
__ Prostate Disease
__ Bowel Irregularity
__ Sexual/Menstrual Dysfunction
__ Venereal Disease

__ Diabetes
__ Hepatitis
__ Anemia
__ Arthritis
__ Osteoporosis
__ Hypertension
__ Depression
__ Gout
__ Stroke
__ Cancer

__ Rheumatic Fever
__ Glaucoma
__ Epilepsy
__ Bleeding Disorder
__ Kidney Disease
__ Thyroid Disease
__ Mental Illness
__ Impairments
__ Other: _____

__ NO KNOW HISTORY

HOSPITILIZATIONS OR SURGERIES

REASON	DATE	REASON	DATE

__ NOT APPLICABLE

HABITS

TOBACCO USE

Smoke cigarettes: __ Never __ NO __ YES
Current smoker: __ Pipe __ Cigar __ Snuff __ Chew
Packs/day: _____ # of years: _____

ALCOHOL USE

Do you drink alcohol? __ YES __ NO
# of drinks a week: ____
___ Beer ___ Wine ____ Liquor

DRUG USE

Do you use marijuana or recreational drugs: __ YES __ NO
Have you every used needles to inject drugs: __ YES __ NO

SEXUAL PREFERENCE

___ Male ___ Female ____ Both male & female

Last Menstrual Cycle: ____-____-____

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NO SHOW/CANCELLATION APPOINTMENT POLICY EFFECTIVE August 1, 2016

We understand that situations arise in which you must cancel your appointment. When you cancel your appointment with a **24-hour notice** it will allow another person to be scheduled in that appointment slot. If we do not receive a call to cancel an appointment, we are unable to offer that slot to other people.

Patients who do not show or cancel their appointment without a **24 hour notice** either via phone or patient portal will be considered as a **NO SHOW** and will be subject to a **$35.00** no show fee.

The No Show/Cancellation fee is the sole responsibility of the patient and must be paid in full before the patient can be scheduled for their next appointment.

Patients who have **3** or more **no show** or **canceled** appointments **in one year** may be subject to termination from the practice.

Our practice firmly believes that good physician and physician assistant relationship is based upon understanding and good communication. Questions about the no show fees should be directed to a member of our billing department at 770-964-1400 option 5.

Please sign that you have read, understand and agree to this No Show policy.

_____ _____

Patient Name (Please Print) **Date of Birth**

_____ _____

Signature of Patient of Patient Representative **Date**