New Patient Intake Form

(Please fill out this entire form)

FamilyCare OF MIDDLE GEORGIA

Dr. Benjamin Ho | Irene Ho, PA-C

Patient Name:		DOB:	Sex Assigned at Birth: ▢ Male ▢ Female Pronouns: ▢ He ▢She ▢They ▢Other
Social Security Number:	Marital Status: ▢ Single ▢ Married ▢ Partner ▢ Widowed ▢ Divorced ▢ Legally Separated	Race: ▢ Caucasian ▢ Hispanic ▢ Asian ▢ African American ▢ Native American ▢ Other: _____	Preferred Language: ▢ English ▢ Other: _____
Home Address:		City:	State / Zip Code
Mobile Phone #:	Alternate Phone #:	Employment/School:	Occupation:
Email Address:		Pharmacy(Name & Street)	

Responsible Party and Emergency Contact:

Responsible Party (Name):	Relationship to Patient:	Social Security Number:
Address (if different from patient's):	City	State / Zip Code
Email Address:	Mobile #:	DOB:

Emergency Contact (Name):	Relationship to Patient:	Social Security Number
Address:	City	State / Zip Code
Mobile #:	Home #:	DOB:

Primary Insurance:

Name of Insurance Company:	Insurance ID:	Group ID:
Policy Holder's Name & Relationship to Patient	Policy Holder's Date of Birth::	Policy Holder's Social Security Number::

Secondary Insurance (If applicable):

Name of Insurance Company:	Insurance ID:	Group ID:
Policy Holder's Name & Relationship to Patient	Policy Holder's Date of Birth::	Policy Holder's Social Security Number::

ASSIGNMENT OF INSURANCE BENEFITS:

The undersigned hereby authorizes my physician or his agent to release any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered, or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as through the undersigned had personally signed the particular claim as described on the attached form:

I, _____, hereby authorize the insurers listed above to pay all insurance benefits to Dr. Ho for his professional services. I understand that I am financially responsible for all charges incurred.

X_____(Signature) Date: _____

Family Care of Middle Georgia

Patient History

Patient's Name: _____ D.O.B.: _____

MEDICAL HISTORY

Current Medical Conditions:
Current Medications:
Other doctors/therapists that patient currently sees:
Previous PCP or Regular Doctor:
Birth History (if you remember): ▢ Full Term ▢ Vaginal Birth Weight: ____lb____oz Length: _____in ▢ Premature ▢ C-section Complications?
Surgical History: ▢ No surgery in the past List Past Surgeries with dates:
Hospitalizations: ▢ No Hospitalizations in the past List Past Hospitalizations with dates:
Allergies: ▢ Not Allergic to Anything _____ Reaction: _____ _____ Reaction: _____ _____ Reaction: _____ Vaccines up to date? ▢ Yes ▢ No ▢ Unsure ▢ Refuse Vaccination

FAMILY HISTORY

Diseases/conditions that run in the family:

Condition:	Who has it? ▢ maternal ▢ paternal	▢ Alive ▢ Deceased ▢ Unknown
Condition:	Who has it? ▢ maternal ▢ paternal	▢ Alive ▢ Deceased ▢ Unknown
Condition:	Who has it? ▢ maternal ▢ paternal	▢ Alive ▢ Deceased ▢ Unknown
Condition:	Who has it? ▢ maternal ▢ paternal	▢ Alive ▢ Deceased ▢ Unknown
Others:		

SOCIAL HISTORY

Who all does patient live with?
Substance(**Patient**): ▢ Smoking ▢ Vaping ▢ Alcohol ▢ Drugs ▢ Smoke Exposure (if patient is a non-smoker) ▢ None
Other Conditions(**Patient's** Social History):

Consent Form

FamilyCare OF MIDDLE GEORGIA

Dr. Benjamin Ho | Irene Ho, PA-C

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Family Care of Middle Georgia (FCMG) to use and/or disclose certain protected health information (PHI) about me to the following Person or Entity to receive the information:

Please list other medical providers, family, friends, etc. who may receive your medical information.

No information will be discussed with those who are not on this list

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

____ (Initial) **PATIENT HEALTH INFORMATION.** I understand that this authorization may include disclosure of information relating to alcohol and drug abuse, mental health treatment, except psychotherapy notes, and confidential HIV-related information unless I exclude this information above. In the event my health information includes any of these types of information, I specifically authorize the release of such information to the person(s) indicated above.

____ (Initial) **INSURANCE PAYMENT.** I hereby authorize direct payment of medical benefits to FCMG for services rendered. I consent to the use or disclosure of my or my child's protected health information by FCMG and, if needed, information from other providers, for the purpose of obtaining payment for my health care bills or to conduct the healthcare operations. I understand that I am responsible for all co-payments, amounts applied to deductibles, and other amounts that may be deemed my responsibility by my contract with my insurance plan. (Due to the vast amount of insurance plans, our staff is unable to know your plan's specific benefits allowed by your insurer. When in doubt, you are encouraged to review your policy and contact your insurance company.) I understand that I am financially responsible for paying any balance not covered by my insurance at the time of service or upon receipt of a billing statement from FCMG. Failure to pay for the services will be sent to a collection agency. All payments are due at the time of the visit. If you are uninsured, you are required to pay for the cost of the office visit before being seen.

____ (Initial) **CANCELLATION POLICY** I understand that if I am unable to keep my appointment, I must notify FCMG at least one day (24 hours) prior to the appointment, or I will be charged a **no show fee($20)** which will not be covered by my health insurance. The no show fee must be paid prior to being scheduled for another appointment. If I am late for my appointment for more than 15 minutes, my appointment will be rescheduled.

____ (Initial) **NO SHOWS -** *1, 2, 3 strikes you're out.* ***FCMG may remind me of my appointment as a courtesy; however, it is my responsibility to keep up with my appointment.*** I am aware that if I miss a new patient appointment twice, I will not be rescheduled. Also, if I have 3 no shows throughout the past 12 months, I understand Dr. Benjamin Ho will no longer be my PCP. I will not be able to make an appointment, but I can try to come in as a walk in.

____ (Initial) **CONSENT TO OBTAIN PRESCRIPTION HISTORY.** I hereby authorize Family Care of Middle Georgia to obtain and review my prescription history. Detailed prescription history provides your physician with information about medications being prescribed by other providers involved in your medical care. This information will improve the accuracy of our medication list in your medical chart and decrease any adverse drug reactions or inaccurate medication information such as medication names or dosages. I understand that my prescription history may be shared with other healthcare providers, pharmacies, insurance companies for treatment purposes.

____ (Initial) **NOTICE OF PRIVACY PRACTICE.** The revised Notice of Privacy Practice (eff 8.31.2018) was provided for my review. I hereby acknowledge that Family Care of Middle Georgia will share my and/or dependent's medical information, as permitted under federal law (HIPAA) and Georgia State law, with my healthcare providers through a health information exchange.

I have read, I understand, and I agree to the provisions of this consent form.

Patient's Name: _____ **D.O.B.:** _____

Name of legal guardian(if not signed by patient)_____ **Relationship:** _____

Signature of patient or legal guardian: _____ **Date:** _____

Thank you for choosing **Family Care of Middle Georgia** *for your healthcare needs.*
Please view our office policies below.

Financial Policy

We have updated our financial policy, and we'd like you to stay informed with our office policies so we can continue to provide you the best services.

Insured Patients: Our practice files directly to your insurance and it is important we always have the correct insurance information from you. If your insurance has changed in anyway, you must inform us. Otherwise, the bill will be your responsibility in full. Additionally, you will be responsible for any co-payments, deductibles, co-insurances and cost shares. All co-pays are to be paid in full before services rendered. A $5 billing fee will be applied any time a copay is asked to be billed.

Non-Insured Patients: Our office will expect payment before services are rendered. There will be no exceptions. Any procedure or lab charges will be explained to you and they will need to be paid before services are rendered.

Payment Methods: At the time of your check-in, you will be notified of any balance due. Our office accepts cash, VISA, Mastercard, and Discover. A payment can be made over the phone using a credit/debit card.

Billing Cycle: Please read and be familiar with the following information - this information can make the difference between an account in GOOD STANDING or in collections status. Statements are mailed monthly on the 15th.

- First Statement: You will receive your first mailed statement after your insurance is filed, insurance pays and if a patient balance is due. You will not receive a statement if there is no patient balance due. Any balance is patient responsibility and should be promptly paid in full within 30 days.
- Second Statement: You will receive a second mailed statement requesting payment in full. An alert is put on your account if balance is past due 60 days. Account is in jeopardy of good standing.
- Third Statement: You will receive a third and last mailed statement with a final notice warning of outside collections. Our intent is to inform you of the seriousness of your delinquent account. Your account is past due 90 days. The agency will start the collections process on the 91st day as well as notify the credit companies. **No appointments can be made until balance is completely paid.**

Paperwork: A fee of $10 is charged for all paperwork and is due when you pick-up the paperwork or before it is mailed/faxed. It will be processed in order the request is submitted by the patients or entities. Please be courteous to others who submitted the request prior to yours, and expect approximately 2 weeks to process any paperwork.
*The fee may be increased due to length and complexity at the discretion of the provider.

Missed appointment: There is a $20 missed appointment fee.

Reasons for Terminating Physician - Patient Relationships

Our providers strive to work with you to treat and manage your health, and it's a teamwork approach. The following are situations in which termination of the physician-patient relationship will be made:

- **Treatment non-adherence:** The patient does not or will not follow the treatment plan
- **Follow-up non-adherence:** The patient repeatedly cancels follow-up visits or is a no-show. 3 strikes and you're out.
- **Verbal abuse:** The patient or a family member is inappropriate and uses improper language with office personnel, exhibits violent behavior, makes threats of physical harm, or uses anger to jeopardize the safety and well-being of office personnel with threats of violent actions
- **Non-payment:** The patient has an outstanding balance and has declined to work with the office to establish a payment plan.

I have read and understand the financial and relationship policies at Family Care of Middle Georgia.

_____	_____	_____
Patient Name	**Patient's or Guardian's Signature**	**Date**

MEDICAL RECORDS RELEASE AUTHORIZATION
FROM PREVIOUS HEALTH CARE PROVIDER

ATTN: MEDICAL RECORDS

RE: _____ _____
Patient's Name | Patient's DOB

_____ _____
Social Security # | Patient's Maiden name (if applicable)

To: _____ _____
Doctor, Hospital, etc. | Fax#

I hereby authorize and request you to furnish medical records to:

FamilyCare
OF MIDDLE GEORGIA

3203 Vineville Ave
Macon, GA 31204
Office: 478-471-0273
Fax #: 478-471-1471

The medical record(s) in your possession, concerning illnesses and/or treatment during the period services were rendered to patient from _____ to _____.

I hereby release you from any legal responsibility or liability that may arise from releasing the foregoing information. A photocopy of the original of this document shall be treated as the same as the original and shall act as a release for the above information.

_____ _____
Signature of patient / guardian / power of attorney | Date

_____ _____
Printed Name of guardian or power of attorney | Relationship to Patient