New Patient Intake Form

(Please fill out this entire form)

FamilyCare OF MIDDLE GEORGIA

Dr. Benjamin Ho | Irene Ho, PA-C

Patient Name:		Date of Birth:	Sex: ▢ Male ▢ Female
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 (if different from patient):

Responsible Party's Name:	Relationship to Patient:	Social Security Number:
Address:	City:	State / Zip Code:
Email Address:	Mobile #:	DOB:

Emergency Contact:

Emergency Contact's 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 #:

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 #:

Patient's Name: _____ Date of Birth: _____

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 ▢ Decline 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 the 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

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION: I grant Family Care of Middle Georgia (FCMG) permission to share protected health information about me to the following persons (i.e. spouse, family members, etc.) or entities listed below. My health information will not be shared with anyone not authorized on this list.

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

INSURANCE AND FINANCIAL POLICY: At Family Care of Middle Georgia (FCMG), we strive to provide clear guidelines on billing and financial responsibilities.

- For insured patients, our practice files claims directly with your insurance provider. It is essential to provide accurate and updated insurance information. If your insurance changes, you must notify us promptly; otherwise, you will be responsible for the full balance.
- Patients are responsible for all co-payments, deductibles, co-insurance, and cost-sharing amounts as determined by their insurance plans. Co-payments must be paid in full before services are rendered, and a $5 billing fee will be applied if a co-payment is billed instead of paid at the time of service. Payment for balances not covered by insurance is required upon receipt of a billing statement, and unpaid balances may be sent to a collection agency.
- For non-insured patients, full payment is required before services are rendered, with no exceptions. Any procedure or lab charges will be explained in advance and must also be paid prior to receiving services.
- By receiving services, you authorize FCMG to receive direct payment of medical benefits for services rendered and to share your or your child's protected health information, if necessary, with other providers for payment or healthcare operations. You also authorize FCMG and its agents to release information needed for claims processing and to submit claims on your behalf without requiring your signature for each claim.
- Additionally, you consent to your insurance provider paying benefits directly to Dr. Ho for professional services rendered and acknowledge financial responsibility for any remaining charges. This policy ensures a transparent billing process and a clear understanding of your financial obligations.

CANCELLATION POLICY: I understand that if I am unable to attend my appointment, I must notify FCMG at least 24 hours in advance. Failure to do so will result in a no-show fee, which is not covered by health insurance. Additionally, if I arrive more than 15 minutes late, my appointment will be rescheduled.

NO-SHOW POLICY: I understand that it is my responsibility to keep track of my appointments, and FCMG may or may not provide courtesy reminders. If I miss a new patient appointment, I acknowledge that I will not be rescheduled. Missed appointments will incur a no-show fee, which is not covered by health insurance and must be paid in full before scheduling the next appointment. I further understand that accumulating three no-shows may result in my dismissal from the practice.

CONSENT TO OBTAIN PRESCRIPTION HISTORY: I authorize Family Care of Middle Georgia (FCMG) to access and review my prescription history. This information helps ensure an accurate medication list in my medical record, reduces the risk of adverse drug reactions, and identifies potential discrepancies in medication names or dosages. I understand that my prescription history may also be shared with other healthcare providers, pharmacies, and insurance companies as necessary for treatment purposes.

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, understood, and agree to the terms outlined in this consent form and the policies of Family Care of Middle Georgia.

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

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 POLICY: Please review the following billing cycle information carefully, as it determines whether your account remains in good standing or is sent to collections.

- **Monthly Statements:** Statements are mailed on the 15th of each month. You will only receive a statement if you have a balance due after your insurance has been filed and payments processed. Balances are your responsibility and must be paid in full within 30 days of the first statement.
- **First Statement:** The initial statement reflects any outstanding balance after insurance payments. Payment in full is required within 30 days to avoid a past-due status.
- **Second Statement:** If payment is not received within 30 days, a second statement will be mailed, indicating the account is past due at 60 days. An alert will be placed on your account, and your good standing may be at risk.
- **Third and Final Statement:** If payment is not received by 90 days past due, a final statement will be mailed, warning of impending collections. On the 91st day, the account will be sent to a collection agency, and credit reporting agencies will be notified. At this point, no further appointments can be scheduled until the balance is paid in full.

PAPERWORK POLICY: A fee is required for all paperwork requests and must be paid at the time of pick-up or before the paperwork is mailed or faxed. Requests are processed in the order they are received. Please allow approximately two weeks for processing and be mindful of others who submitted requests before yours. The fee may vary based on the length and complexity of the paperwork, as determined by the provider.

DISMISSAL POLICY: At FCMG, our providers are committed to a collaborative approach in managing and treating your health. We view the physician-patient relationship as a partnership built on mutual respect, trust, and shared responsibility. However, certain situations may necessitate the termination of this relationship. These situations include, but are not limited to:

- **Treatment Non-Adherence:** The patient consistently refuses to follow the recommended treatment plan.
- **Follow-Up Non-Adherence:** The patient repeatedly cancels or fails to attend follow-up appointments.
- **Verbal or Physical Abuse:** The patient or a family member engages in inappropriate behavior, including the use of disrespectful, offensive, or threatening language, engaging in violent actions, or acting in a manner that compromises the safety and well-being of office personnel.
- **Dishonesty:** Any behavior that undermines trust or the integrity of the physician-patient relationship.
- **Poor Rapport:** The relationship between the patient and the provider has deteriorated to the point where effective care is no longer possible.
- **Non-Payment:** The patient has an outstanding balance and declines to work with the office to establish a payment plan.

We encourage open communication to address any concerns and ensure the best possible care. However, under the above circumstances, FCMG may choose to end the physician-patient relationship.

I have read, understood, and agree to the terms outlined in this consent form and the policies of 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