NEW PATIENT HISTORY FORM – PEDIATRICS

This form is designed to give us as much information as possible about your child. It may seem that much of it is not relevant to your child, but only by knowing everything possible can we decide what is really important. Please answer all of the questions that you can. If you are unsure of an answer, if a question does not pertain to your child, or if you do not want to answer a question, just leave it blank.

Child's Full Name and Nickname		Date of Birth	
Address		Gender	
Cell/Home Telephone #		Race	
Mother		Father	
Full Name		Full Name	
Address (if different)		Address (if different)	
Work Phone #		Work Phone #	
Cell Phone #		Cell Phone #	
Email Address		Email Address	

RESPONSIBLE PARTY INFORMATION

Last Name: _____ First Name: _____MI:_____SSN:_____

Mailing Address: _____City: _____State:_____ Zip: _____

Home Phone: _____ Work Phone: _____Cell Phone:_____

Date of Birth: _____/_____/_____ Relation to Patient: _____E-mail address:_____

Employer Name: _____Address:_____Phone:_____

INSURANCE INFORMATION (Please enter Primary Policy Holder's information here i.e self, spouse, mother or father)

Primary Insurance Company _____ID #:_____Group #:_____

Subscriber Name: _____ Date of Birth: _____/_____/_____ SSN:_____

Relation to Patient: _____Phone Number:_____

How did you hear about our practice? _____

PREGNANCY/BIRTH:

Describe any problems with the pregnancy?_____

List any medications taken during pregnancy?_____

Hospital (or home) where child was born: _____ Name of doctor or midwife_____

Was baby born at the expected time? _____ If No: When was baby expected? _____

Birth: (Check one) Vaginal _____ C-section_____ Forceps_____ Vacuum_____

Type of Anesthesia: None _____ Epidural _____ Other _____

Birth Weight _____ Apgar score, if known: _____

Describe if the baby had any problems as a newborn:_____

IMMUNIZATIONS: If you have not already, we request that you provide a record of all past immunizations as soon as possible.

PAST AND CURRENT ILLNESSES:

Does your child have any chronic or recurrent medical problems? Please list.

Has your child ever been hospitalized or had surgery? If so, please list dates, hospital, and reason.

1. _____
2. _____
3. _____

List any medicines your child regularly takes: _____

List any allergies your child currently has: _____

FAMILY INFORMATION AND MEDICAL HISTORY

	NAME (include last name if different)	Birth Date	HEIGHT	HEALTH PROBLEMS	OCCUPATION
Father					
Mother					
Children					
1st					
2nd					
3rd					
4th					
5th					
6th					

Who lives in your child's home? _____

Do you have smoke detectors at home? _____ Do you have carbon monoxide detectors at home? _____

List Pets in the home _____ Does anyone in the home smoke? _____

Are there any guns in the child's home? _____

Please indicate WHO in your family has had the following (if any). If no family history of that problem, please place an "X".
Please include your child's parents, siblings, maternal and paternal grandparents, aunts, uncles, cousins, nephews, nieces.

Diabetes		Heart Problem		Asthma	
ADHD/Learning Problem		Cancer		Allergies	
High Blood Pressure		Poor Sight or Deafness		Cholesterol Problems	
Emotional Problem/ Depression		Thyroid Problem		Kidney Problems	
Drug or Alcohol Abuse		Bleeding Tendency		Death at Young Age	
Neurologic Problem/ Seizures		Stomach/Bowel Problems		Rheumatologic (Lupus, Rheumatoid Arthritis, Etc.)	

Please further explain any items checked above as needed

_____

_____

Have any of your children died? _____

Are there any other illnesses that run in your family?_____

LIST ANY CURRENT CONCERNS ABOUT YOUR CHILD'S HEALTH OR DEVELOPMENT:

_____

Family Care Group of Thomson Inc.

ASSIGNMENT OF BENEFITS AND RELEASE

DARYL WILEY, MD
CHRIS SHEPPARD, MD
AMANDA BRITT, MD
ROBERT POLGLASE, MD
MERRITT MCLAUGHLIN, MD
TYLER PROVOST, DO
SCOTT STAMPER, FNP, PNP
MICHAEL MCDANIEL, PA-C
MEGAN WILEY, FNP
LAURA GILLEN, PA-C
KIMBERLY CLARK-BRAKE, FNP
MALLORY MONTES, DNP, FNP

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize Family Care Group of Thomson, Inc. to release any medical information necessary to process insurance claims relating to the medical care rendered by Family Care Group of Thomson, Inc.

ASSIGNMENT OF BENEFITS:

I authorize payment of medical benefits to Family Care Group of Thomson, Inc. for any medical care rendered to myself or to my dependents. I understand that I am responsible for my co-payment, deductible and/or any amount not covered by my insurance. I further acknowledge that if the practice is unable to verify my benefit coverage prior to services being rendered, I accept financial responsibility for any non-covered services.

FINANCIAL POLICY:

We request payment for professional services on the day that services are provided. By eliminating billing, we can help keep your medical costs down. We accept cash, check, Visa, Mastercard, and American Express. We must make a copy of your insurance cards on the day of your first appointment and must verify coverage. Your co-payment will be collected at check in. If you have not met your deductible, we ask that you pay in full at the time of your appointment. Should it be necessary to send a second statement to you on outstanding charges, you may be billed a service charge.

Printed Name: _____

Signature: _____ **Date:** _____

Family Care Group of Thomson, Inc.

315 Fluker Street, P.O. Box 780, Thomson, GA 30824 (706) 595-1090

2508 University Drive, Thomson, GA 30824 (706) 595-1090

123 North Washington Street, Lincolnton, GA 30817 (706) 359-6070

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAYBE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

FOR PAYMENT: We may use and disclose medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the practice or the hospital. For example, we may disclose medical information about you to people outside the practice who may be involved in your medical care, such as family members, clergy or other persons that are a part of your care.

FOR HEALTH CARE OPERATIONS: We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other practice personnel for review and learning purposes. For example: we may review your record to assist our quality improvement efforts. We may make your medical information available electronically through state, regional or national information exchange services which help make your medical information available to other healthcare providers who may need access to it in order to provide care or treatment to you. Participation in health information exchange services also provides that we may see information about you from other participants.

WHO WILL FOLLOW THIS NOTICE: This notice describes our practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other practice personnel.

BUSINESS ASSOCIATES: There are some services provided in our organization through contacts with business associates. An example is certain tests performed by outside laboratories. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked them to do and bill you or your third party payer for services rendered. To protect your health information, however, we require the business associates to appropriately safeguard your information.

APPOINTMENT REMINDERS/TREATMENT ALTERNATIVES/HEALTH RELATED BENEFITS AND SERVICES: We may use and disclose Protected Health Information to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

RESEARCH: We may use and disclose your Protected Health Information for research purposes, but we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your Protected Health Information.

AS REQUIRED BY LAW: We will disclose Protected Health Information about you when required to do so by international, federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Protected Health Information when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.

Workers' Compensation:. We may use or disclose Protected Health Information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

PUBLIC HEALTH: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

LAW ENFORCEMENT: We may disclose Protected Health Information for law enforcement purposes as required by law or in response to a valid subpoena.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

ABUSE, NEGLECT, OR DOMESTIC VIOLENCE: We may disclose Protected Health Information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or if we are required or authorized by law to make that disclosure.

MILITARY AND VETERANS: If you are a member of the armed forces, we may disclose Protected Health Information as required by military command authorities. We also may disclose Protected Health Information to the appropriate foreign military authority if you are a member of a foreign military.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION: We create a record of the care and services you receive at the practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the practice, whether made by practice personnel or by your personal doctor. The law requires us to: make sure that the medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health –related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

RIGHT TO A PAPER COPY OF THIS NOTICE: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

RIGHT TO INSPECT AND COPY: You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

RIGHT TO AMEND: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

RIGHT TO AN ACCOUNT OF DISCLOSURES: You may request an "accounting of disclosures." This is a list of the disclosures FCGT has made of Protected Health Information about you.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS: You may request that we communicate with you about medical matters in a certain way or at a certain location.

RIGHT TO REQUEST RESTRICTIONS: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

RIGHT TO REVOKE YOUR AUTHORIZATION: You may revoke your authorization to use or disclose Protected Health Information except to the extent that the action has already been taken.

RIGHT TO OPT OUT OF FUNDRAISING ACTIVITIES: We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications.

RIGHT TO RECEIVE NOTICE OF A BREACH: You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

OUT OF POCKET PAYMENT: If you paid in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

CHANGES TO THIS NOTICE: We reserve the right to change this notice. We will post a copy of the current notice in the practice's waiting room.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact Kristen Francis, Practice Manager at 706-595-1090. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION: Other uses and disclosures of medical not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you have questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEATLH INFORMATION FOR PAYMENT, TREATMENT AND HEALTH CARE OPERATIONS.

By signing below, you hereby consent for this Practice to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purposes of treatment, payment and health care operations. You may refuse to sign this consent form.

You should read the notice of Privacy Practice for PHI documented above before signing the Consent. The terms of the Notice may change from time to time, and you may always get a revised copy of it by asking the Privacy Officer for this Practice.

You have the right to request that the Practice restrict how PHI is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to requested restrictions; however, if the practice agrees to your requested restrictions, the restriction is binding on it.

Information about you is protected under federal law, and you have the right to revoke this Consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Officer). By signing below, you recognize that the protected health information used or disclosed pursuant to this Consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

You may communicate with the following individuals regarding my condition or course of treatment:

_____

You may communicate confidential information to me, including invoices for services, to the following address and/or phone numbers:

_____

As a personal representative, I have authority to act for the individual because I am the individual's_____.

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights. I hereby acknowledge that Family Care Group of Thomson, Inc. will share my medical information, as permitted under federal law (H.I.P.A.A) and Georgia State Law, with my healthcare providers through a health information exchange.

_____PATIENT NAME: _____

Patient or Patient's Personal Representative Signature Date

PATIENT DATE OF BIRTH:_____ DATE:_____

Family Care Group of Thomson, Inc.

315 Fluker Street
Thomson, GA 30824

2508 University Drive
Thomson, GA 30824

123 N. Washington St.
Lincolnton, GA 30817

Daryl C. Wiley, MD
Chris Sheppard, MD
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Tyler Provost, DO
Laura Gillen, PA
Kimberly Clark-Brake, FNP

Scott Stamper, NP
Michael McDaniel, PA
Megan Wiley, NP
Mallory Montes, DNP, FNP

AUTHORIZATION FOR MEDICAL RECORDS RELEASE

PATIENT NAME: _____

DATE OF BIRTH:___/___/_____ SS# _____

Respectfully requests that the providers of Family Care Group of Thomson, Inc. provide medical care to me and do authorize, direct, and request:

_____
(Physician Name, Address, Telephone and Fax Number)

_____

Deliver all of my medical records to Family Care Group of Thomson, Inc. or designee.

INFORMATION TO BE RELEASED:

___Discharge Summary
___History and Physical
___Laboratory Reports
___X-ray Reports
___EKG/Cardiovascular

___Physician Orders
___Operative Report
___Immunization Record
___Progress Notes
___Entire Record

This_____day of_____20___
(Date) (Month)

_____
(Signature of Patient or Legal Guardian)

_____
(Witness)