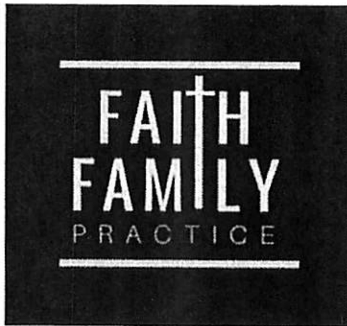

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PATIENT INFORMATION

First Name: ______________________ MI. ________ Last Name: ______________________

DOB: ____/____/____ SSN: ____-____-____ SEX: ________ Marital Status: ________

ADDRESS: ____

CITY: ______________________ STATE: ________ ZIP: ________

HOME#(___)______-______ CELL # (___)______-______ WORK # (___)____-______

EMAIL:______________________ Can we email you health information? YES or NO

If patient is a student/minor, please list the responsible party's information:

Name:______________________Relation:____________ # (___) _____-______

EMERGENCY CONTACT

Name: ______________________ Relation: ____________ # (___) ____-______

I authorize Faith Family Practice to communicate my health information with the following:

Name: ______________________ Relation: ____________ #(___) ____-______

Name: ______________________ Relation: ____________ #(___) ____-______

Patient/Guardian Signature: ______________________________

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INSURANCE INFORMATION

Primary Insurance Carrier: ______________________________

Policy # ______________________ Group #__________________

Policy Holder Name:________________________ DOB: ____/____/____

Policy Holder SSN: ______________________

Secondary Insurance Carrier:______________________________

Policy # ______________________ Group #__________________

Policy Holder Name:________________________ DOB: ____/____/____

Policy Holder SSN:______________________

A COPY OF ALL INSURANCE CARD(S) AND DRIVERS LICENSE WILL BE REQUESTED

PAST MEDICAL HISTORY

Circle all that apply

Heart Disease Hypertension Heart Attack High Cholesterol Stroke

Diabetes - Type I / Type II COPD Asthma Thyroid Disease GERD

Liver Disease Kidney Disease Gout Arthritis Migraines ADD/ADHD Cancer

OTHER:____

Age or Year of last Colonoscopy?: ______________________________

Age or Year of last Bone Density?:______________________________

Age or Year of last Mammogram?:______________________________.

Age or Year of last Pap Smear?:______________________________

SURGICAL HISTORY

Have you had any surgeries, if Yes, please list:

TYPE:______________________________YEAR:______________

TYPE:______________________________YEAR:______________

TYPE:______________________________ YEAR:______________

TYPE:______________________________YEAR:______________

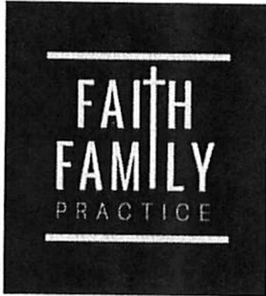
Family History

Mother	Still Living? (Circle)	Yes	No	Health Problems:______________
Father	Still Living? (Circle)	Yes	No	Health Problems:______________
Brother	Still Living? (Circle)	Yes	No	Health Problems:______________
Sister	Still Living? (Circle)	Yes	No	Health Problems:______________

Social History

Do you smoke? (Circle) Yes / No If "Yes" ; How many packs per day?______How long?__________

Do you drink? (circle) Yes / No If "Yes"; How often?____________________ How long?________



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MEDICATIONS

Local Pharmacy:________________________ Mail order Pharmacy:__________________

Medication: ________________________ Dose:______________ Frequency:___________

Medication: ________________________ Dose:______________ Frequency:___________

Medication: ________________________ Dose:______________ Frequency:___________

Medication: ________________________ Dose:______________ Frequency:___________

Medication: ________________________ Dose:______________ Frequency:___________

Medication: ________________________ Dose:______________ Frequency:___________

Medication: ________________________ Dose:______________ Frequency:___________

Medication: ________________________ Dose:______________ Frequency:___________

Medication: ________________________ Dose:______________ Frequency:___________

Medication: ________________________ Dose:______________ Frequency:___________

Do you have allergies to any medication? (circle) Yes / No If Yes, Please list:

Are you allergic to Latex? (circle) Yes / No

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Dr. Clay Lee, D.O.

Bradley Page, PA-C

Roxy J Sheffield, PA-C

Jerry Mullis, MD

Leanna J. Lewis, FNP

Dillon Veal, PA-C

.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, ____, **DOB:** ____/____/____

Request the release of my Medical records from:

Dr. ____

Address: ____

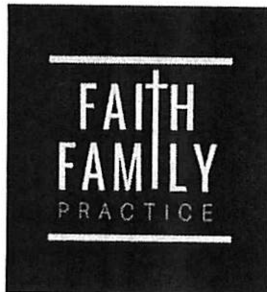
Phone #: ______________________________ **Fax#** ______________________

Records to be released to Faith Family Practice.

(Records to include: a photographic copy of: one year of office notes, most recent labs, xray reports and colonoscopies)

Patient/Guardian Signature:____

Date:_________________________



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FINANCIAL POLICY

As your physician, we are committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance and your understanding of our payment policy.

PAYMENT IS DUE AT TIME OF SERVICE

All co-pays, deductibles and the percentage you are responsible for, is due at time of service. If you are Self Pay, you MUST pay the Self Pay price in full at time of visit, Unless other arrangements have been made with the Practice Manager, prior to your visit.

We accept Cash, Master card, Visa and American Express. We DO NOT accept personal checks?

No show appointments

Patients who do not cancel and NO SHOW for your appointment could be charged a $25.00 NO SHOW Fee.

WORKERS COMPENSATION AND AUTOMOBILE ACCIDENTS

We DO NOT accept workers compensation or automobile accident claims. If this is the case, you are responsible for your account at the time of service.

My signature below indicates that I have read and understand the Financial policy and appointment policy.

Signature:_______________________________________ Date:____________________

Printed Name:____

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

With my consent, Faith Family Practice, LLC, may use and disclose protected health information (PHI) about me to carry out treatments and healthcare operations (TPO). Please see Faith Family Practice's Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Faith Family Practice reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices ma be obtained by sending us a written request to the Privacy Officer, Faith Family Practice, 2005-C Pioneer St. Waycross, GA 31501.

With my consent, Faith Family Practice, may call my home or other designated location and leave a message on voicemail or in person in reference to any items that may assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results and other test results.

With my consent, Faith Family Practice may mail to my home or other designated location any items that assist in the practice carrying out TPO, such as appointment reminder cards, and patient statements as long as they are marked Personal and Confidential.

With my consent, Faith Family Practice may email to the email address I have on file any items that assist the practice in carrying out TPO, such as appointment reminders, patient statement information and other things. I have the right to request that Faith Family Practice restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but it if does, it is bound by this agreement.

By signing this form, I am consenting to Faith Family Practice's use and 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, Faith Family Practice may decline to provide treatment to me.

Patient's Name: ________________________________ Date of Birth: ______________________

Signature of Patient or Legal Guardian: ____________________________ Date: ____________

Print Name of Legal Guardian: ____

ALL PAYMENTS, CO-PAYMENTS AND DEDUCTIBLES ARE DUE AT TIME OF SERVICE

PLEASE BE SURE TO COMPLETE ALL FORMS

Consent for Treatment

1. I ___________________________ (patient name) give permission for **Faith Family Practice** to administer medical treatment as deemed necessary by the medical provider on call.

2. I give **Faith Family Practice** permission to file insurance benefits for the care I receive.

   I also understand that:

   - **Faith Family Practice** will have to send my medical record information to my insurance company.
   - I am responsible for all Co-pays and the percentage as required by my insurance, **at the time of service.**
   - I understand that I am responsible for the cost of these services if my insurance does not pay.

3. I understand that if I do not have insurance, I am considered **Self-Pay** and I am responsible for the payment of services before services are rendered.

   - I also understand that as a Self-Pay patient I am responsible for any medications and or procedures performed during this visit. These charges are expected to be paid prior to my leaving the facility.

4. I understand:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with my clinician.

______________________________________   ____________________
Patient's Signature   Date

______________________________________   ____________________
Parent or Guardian Signature   Date
(Children under 18)

______________________________________   ____________________
Print name   Date

______________________________________   ____________________
Witness (Staff)   Date

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URINE DRUG SCREEN (UDS) PROTOCOL

Basic UDS: The test is medically necessary to determine the presence or absence of drugs or drug classes in a urine sample.

Definitive UDS: The test is medically necessary to identify specific medications, illicit substances and metabolites. This test is being used to identify a specific substance or metabolite that is in a large class of drugs or that is inadequately detected or not detected by Presumptive UDS, and to identify drugs when a definitive concentration of a drug is needed to guide management.

Definitive UDS: This test is medically necessary to identify non-prescribed medication or illicit use for ongoing safe prescribing of controlled substances.

Definitive UDS: This test is medically necessary to rule out error as the cause of a Presumptive UDA result.

Definitive UDS: This test is medically necessary to identify a negative, or confirm a positive, Presumptive UDS result that is inconsistent with a patient's self-report, medical history, presentation, or current prescribed medication plan.

Definitive UDS: This test is medically necessary for use in a differential assessment of medication efficacy, side effects or drug-drug interaction;

Non-opioid alternatives for the treatment of pain have been discussed with the patient. A treatment plan has been created and discussed with the patient. A physical exam, assessment of patient compliance with opioid agreement, family/social assessment, opioid risk tool, and assessment of the PDMP were utilized.

The opioid risk tool categorized the patient as "low risk" meaning that the patient has a low likelihood of aberrant drug-related behavior and therefore should undergo testing 1-2 times every 12 months.

The opioid risk tool categorized the patient as "moderate risk" meaning that the patient has a reasonable likelihood of aberrant drug-related behavior and therefore should undergo testing 1-2 times every 6 months.

The opioid risk tool categorized the patient as "high-risk" meaning that the patient has a high likelihood of aberrant drug-related behavior, including the use, misuse, and/or abuse of prescribed medications, non-prescribed medications and/or illicit-controlled substance, as well as diversion, and therefore should undergo testing 1-3 times every 3 months.

Change in frequency of UDS: A change in the frequency of UDS testing is medically necessary because of the need to asses patient response to a newly prescribed medication, patient side effect profile has changed, drug-drug interaction, sudden change in patient's medical condition, and/or patient admits to use of illicit or non-prescribed controlled substance.

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PATIENT/DOCTOR TREATMENT & MEDICATION AGREEMENT

Faith Family Practice is primarily a Family Medical practice as opposed to a Pain Management practice.

The purpose of this
Agreement is to prevent misunderstandings about certain medicines that might be prescribed for a pain management. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals.

This Agreement is essential to the trust and confidence necessary in a physician/patient relationship and the trust that the physician undertakes to treat the patient based on this Agreement.

By signing this agreement you will have read, understood and agreed to these rules:

- **If I break this agreement, my doctor may stop prescribing my medications and I may be DISCHARGED from the practice.**
- **I will keep Faith Family Practice notified OF MY CURRENT PHARMACY AND THEIR PHONE NUMBER.**
- **I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.**
- **I will not use ANY medications that were not prescribed to me or ILLEGAL substances (narcotics) (e.g., heroine, cocaine, methamphetamines, LSD.)**
- **If recommended by the physician, I will submit to an evaluation by an addiction specialist, which may include a psychiatric evaluation and subsequent treatment.**
- **I will not SHARE, SELL OR TRADE, my medication with anyone.**

• I will not attempt to obtain any controlled pain medication from any other doctor or practice.
• I will SAFEGUARD my pain medication from loss or theft. Lost or stolen medicines WILL NOT be replaced.
• Refills of my prescriptions, for pain medication will be made only during regular office hours. All refill requests must be made THREE business days in advance. NO REFILLS WILL BE AVAILABLE DURING EVENINGS, WEEKENDS OR HOLIDAYS.
• I understand that I must be seen at a minimum of every NINETY DAYS to request a Schedule II controlled medication (opioid) refill or my refill will be denied until I am seen.
• I authorize my doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation or any possible misuse, sale or other diversion of my pain medicine. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.
• I authorize my doctor to provide a copy of this agreement to my pharmacy.
• I will submit to a blood or urine test every NINETY DAYS and also at any other time as requested by my doctor to determine compliance with my program of pain control medication.
• I will use my medicine at a rate no greater than the prescribed rate and that use of my medication at a greater rate will result in my being without medication for a period of time.
• If at any time I break my medication contract, I am aware that the local Sheriff's Office may be notified and my records could be released to them.

I agree to follow these guidelines that have been fully explained to me. all of my questions and concerns regarding treatment and medications have been adequately answered. If requested, a copy of this Agreement has been given to me.

This Agreement has been reviewed and signed on this ___________day of _____________ in the year of ________________.

Patient Name(printed): ____

Patient/Guardian Signature:____