Evergreen Primary Care and Wellness, PC

Malcolm M. Traxler, Jr., MD
Internal Medicine
Heather B. Wanner, FNP
Family Medicine

PATIENT FACE SHEET

Primary Care Physician_____

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid
Is this your legal name? ❑ Yes ❑ No	Preferred Name		Date of Birth / /	Sex ❑ M ❑ F ❑ Other
Home Address			City	State ZIP Code
Billing Address (If different from home address)			City	State ZIP Code
Home Phone: ( )	Cell Phone: ( )	Preferred Number: ❑ Home ❑ Cell		OK to Leave Voicemail? ❑ Yes ❑ No

Preferred Pharmacy: _____ Pharmacy Phone Number: ( )

Email Address: _____

Occupation	Employer	Employer Phone No. ( )

Referred to Office by (Please check one box) ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital
❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ Other _____

Other Family Members Seen Here

PRIMARY INSURANCE (PLEASE HAND ALL INSURANCE CARDS & ID TO THE RECEPTIONIST)

Name of Primary Insurance

Subscriber's Name	Subscriber's Date of Birth / /	Group #	Policy #	Co-Payment $

Patient's Relationship to ❑ Self ❑ Spouse ❑ Child ❑ Other _____

SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

Name of Secondary Insurance

Subscriber's Name	Subscriber's Date of Birth / /	Group #	Policy #	Co-Payment $

Patient's Relationship to ❑ Self ❑ Spouse ❑ Child ❑ Other _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative	Relationship to Patient	Cell Phone No. ( )	Home/Work Phone No. ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Evergreen Primary Care and Wellness, PC to release any information required to process my claims.

X _____
PATIENT/GUARDIAN SIGNATURE DATE

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PROTECTED HEALTH INFORMATION RELEASE FORM

Patient Name:_____Date: _____

(1) Concerning matters of my health, I give permission for Evergreen Primary Care and Wellness, PC representatives to speak with:

Name of person(s)_____relationship to patient _____

Name of person(s)_____relationship to patient _____

Name of person(s)_____relationship to patient _____

Name of person(s)_____relationship to patient _____

2) I request that use and disclosure of the above described information be restricted in the following manner [description of restriction]:

_____

_____

(3) I request that my protected health information not be disclosed to the following individuals or entities [list individuals or entities to which information would not be disclosed]:

_____

_____

Signature of patient:_____ Date: _____

Evergreen Primary Care and Wellness, PC
2450 Atlanta Hwy Suite 803
Cumming, GA 30040
p(470)253-7944
f(678)807-6144
www.evergreenpcw.com

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PATIENT HISTORY

ALLERGIES: _____

Current Medications		
Please include vitamins, herbal or natural supplements & prescription medications		
Medication Name	*Dosage*	*How Often?*

Other Current Providers	
Name of Provider	**Reason for Treating You**

History				
Please check to indicate if you have ever had the following conditions.				
❑ Arrhythmia	❑ Asthma	❑ CHF	❑ CAD	❑ Depression
❑ Diabetes	❑ Emphysema	❑ Eye problems	❑ Heart attack	❑ Hepatitis
❑ High blood pressure	❑ Kidney disease	❑ Seizures	❑ STD	❑ Stroke
❑ Thyroid disease	❑ Tuberculosis	❑ Other: _____		

Hospitalization/Surgery History		
Type of surgery / reason for hospitalization	*Location*	*Date*

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Social History			
Do you use any tobacco products?	Yes	No	I Quit_____ago
Number of cigarettes each day? _____			
For how many years? _____			
Other forms of tobacco used? _____			
Do you drink alcohol?	Yes	No	I Quit_____ago
How Much? _____			
How Often? _____			
Have you regularly used drugs?	Yes	No	I Quit_____ago
Are you still using them? _____			
What are you using? _____			

Immunization History			
	Approximate Date		*Approximate Date*
Tetanus	_____	Influenza	_____
Pneumonia	_____	Hepatitis B	_____
Other	_____	Other	_____

Family History	None	Mother	Father	Sister	Brother	Grandmother (mothers side)	Grandfather (mothers side)	Grandmother (fathers side)	Grandfather (fathers side)	Child	Other (Please explain)
Alcoholism											
Cancer											
Diabetes											
Heart Disease											
High Blood Pressure											
High Cholesterol											
Osteoporosis											
Mental Illness											
Stroke											
Thyroid Disease											

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FINANCIAL & OFFICE POLICY

Health Insurance: We are contracted with most insurance plans as well as Medicare. In order to verify your coverage and keep our records current, we will ask for your insurance card at your initial visit. If you do not have your insurance card and we cannot verify coverage with the information you give us we will ask you to pay for your visit in full at the time of service.

- Please be aware that you are responsible for the charges billed for the services you receive at our office. If your insurance does not remit payment we will bill you for those services.
- If you do not have health insurance you will be responsible to pay for the visit in full at the time of service.
- Services not covered by your insurance: We make every effort to order tests that meet "medical necessity" guidelines set by Medicare and insurance plans. However, we cannot possibly know what is covered under every plan. If your insurance does not cover certain services you will be responsible for those charges. If you prefer you do have the option of calling your insurance to check coverage prior to receiving services.

Payment for services: Co-payments and un-met deductibles are due at the time of service. If you have a balance due on your account for claims that have already been processed by your insurance company you will be asked for that payment at your next visit. If you do not have a follow-up visit scheduled, you will receive a statement in the mail. Other payment arrangements can be made with our billing department. There is a $35 fee for all returned checks we receive.

_____ (Please initial) Cancellation/Missed Appointments: We charge $50 to those patients who fail to give proper noticed for any missed appointments. We ask for 24 hour notice on appointment cancellations so that we may open that appointment time for other patients that may wish to be seen. If you arrive late to your scheduled appointment we have the right to see other patients during your time slot. You have the option of waiting until the next appointment or rescheduling to another day.

_____ (Please initial) Medication refills: We require 48 hour notice to refill any medication. In certain cases we may require an office visit before we will refill a medication.

Physicals: If you are sick at your physical we reserve the right to charge for a brief sick visit if there is need to spend extra time. You, of course, have the right to be seen for the sick visit only and/or reschedule the checkup.

I have read and understand these policies and agree to abide by them. I understand that I have a right to obtain a copy of this for my personal records, when requested.

Patient signature:_____Date:_____

Name/signature of responsible party:_____

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HIPAA COMPLIANCE STATEMENT

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. At Evergreen Primary Care and Wellness, PC, we are committed to protecting your privacy. We comply with all federal, state, and local laws. This notice describes how we use your health information. It describes some of your rights and some of our responsibilities.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit our office, we record your symptoms, physical examination, test results, diagnosis, and treatment. This information enables us to: plan for your care, communicate with others who care for you, report to your insurance carrier, bill for our work, and improve the quality of our care.

YOUR RIGHTS

Although your chart belongs to our practice, the information contained in the chart is yours. You have the right to: inspect your records, obtain a copy of your chart, correct your records, and tell us not to release your information.

OUR RESPONSIBILITIES

We are required to: maintain the privacy of your health information; send needed health information to other medical providers, and release information to insurance companies, certain government agencies, and others. We may be required to release some information, even without your permission.

EXAMPLES OF HOW YOUR INFORMATION IS USED

Your health information will be recorded and used to plan your treatment. Reports may be sent to other doctors to help them plan your treatment. Bills will be sent to your insurance company. The information in the bills will include confidential information such as your name, address, diagnosis, and treatment. In providing your care, we may communicate with other individuals or businesses. Examples include other physicians and/or laboratories. To protect your privacy, we ask our business associates to safeguard your information.

Patient Signature: _____ Date: _____

Name of Responsible Party: _____

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CONSENT FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ **Patient DOB:**_____

Release Records From: _____

Phone:_____ Fax:_____

Release Records To: **Evergreen Primary Care and Wellness, PC**

Phone: 470) 253-7944 Fax: 678) 807-6144

Records Requested:

☐ Laboratory Reports ☐ X-Ray Reports ☐ Any & All

☐ Diagnostic Studies ☐ Consultation(s)
☐ Films / Imaging studies ☐ Other _____

Dates of Records Requested: From:_____ To: _____

Records Shall Be Used For:
☐ Acute Care ☐ Second Opinion ☐ Continuation of Care

Records Shall Be Delivered Via:
☐ Fax ☐ US Mail ☐ Other

Consent:
I hereby authorize the named above to deliver the medical records to Evergreen Primary Care and Wellness. I, the patient or patient's representative have the legal right to inspect, copy, and request delivery as specified of this protected health information within the next 30 days in accordance with Public Law 104-191(HIPPA-1996).

Patient Signature:_____ Date:_____

Printed Name of Legal Representative: _____

Representative's Signature: _____

This consent is valid for 90 days from the date signed.
This request is confidential and intended for the addressee only. Disclosure, copying, altering, or communication of this message if you are not the addressee is prohibited by law.

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