**PLEASE PRINT**

**NEW PATIENT INFORMATION**

|  |
| --- |
| Patient's Last Name First Middle Date of Birth Social Security Sex Race Marital Status |
|  |
| Mailing Address City State Zip Code |
|  |
| Home Telephone Cell Phone |
|  |
| Employer Occupation (indicate if student) How long employed? Work Telephone |
|  |
| Employer's Street Address City State Zip Code |
|  |
| **SPOUSE OR PARENT'S INFORMATION** |
| Spouse or Parent's Name Social Security Date of Birth Number of children and ages |
|  |
| Spouse or Parent's Employer Occupation (indicate if student) How long employed? Work Telephone  |
|  |
| Employer's Street Address City State Zip Code |
|  |
| Emergency Contact Outside Household Telephone Number Relationship to Patient |
|  |

**Payment for services is expected the day of service. This includes all co-pays and deductibles.**

**INSURANCE AUTHORIZATION AND ASSIGNMENT**

**I request that payment of authorized Medicare/Other Ins. Company benefits be made to me or on my behalf to Statesboro Family Practice Clinic for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release, to Health Care Financing Administration and its agents, any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 form is completed, my signature authorizes the release of the information to the insurer or agency shown. In Medicare/Other Ins. Company assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare/Other Insurance Company and collectable at time of service.**

**ACKNOWLEDGEMENT OF AVAILITY OF NOTICE OF PRIVACY PRACTICES**

**By signing this form, I acknowledge that I have been informed that a copy of the practice's Notice of Privacy Practices is available upon request for review, and that upon request, I may obtain a copy. A copy is also in the waiting area.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print Name Signature Date**

**Statesboro Family Practice**

658 Northside Drive East, Suite A

Statesboro, GA 30458

Phone: (912) 764-9684 Fax: (912) 489-8676

**Disclosure of Protected Health Information**

**PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_**

1. Please list any family members or other persons to whom we may release information concerning your medical records:

NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PH # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PH # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How or where do you want to receive calls/messages about your appointments, lab results, reminders or other health care information? (choose one)

\_\_\_\_ Patient Portal

\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. May we leave messages on your voicemail or answering machine?

YES \_\_\_\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_\_\_\_\_

4. If you don’t have an answering machine or voice mail at home, may we leave a message for you to call us at your place of employment or leave a message on your work voicemail?

YES \_\_\_\_\_\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Going **GREEN!!!**  How would you like to receive billing statements?

 \_\_\_\_\_\_\_\_\_E-Mail \_\_\_\_\_\_\_\_\_\_Mail \_\_\_\_\_\_\_\_\_Both

6. Current e-mail for patient portal and billing statements, if applicable: (please print legibly)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. I authorize Statesboro Family Practice to verify my medication history.

YES \_\_\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_\_\_\_\_

**This remains in effect until the end of the year or until I give written notification to discontinue.**

Patient/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian of minors under age 18 has access to medical records, with the exception of any State Law protecting the privacy of information of minors.**

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH:\_\_\_\_\_\_\_\_\_\_\_\_

**What is the reason for your visit today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical History:**  Have you ever had any of the following medical problems? Circle yes or no.

 Explain yes answers:

Arthritis or gout Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart disease or heart attack Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High blood pressure Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High cholesterol Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stroke or pinstroke Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asthma or emphysema Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ulcers or digestive problems Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hepatitis or liver problems Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Migraine headaches Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sinus or allergy problems Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Epilepsy or seizures Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thyroid problems Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anemia or Blood diseases Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Depression or Anxiety Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol or drug problems Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sleep apnea Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Osteoporosis Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Kidney stones Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any medical problems not listed above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you see any other physicians (specialists)? If so, list here:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgery History:** Please list any surgeries (operations) you have had and the year it was done.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications:** Please list all prescription and over the counter medications you take (include dosage).

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_6.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_8.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_10.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What pharmacy do you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies or Drug Reactions:** Please list name of drug and type of reaction.

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:**

 **Living Deceased Any medical problems or cause of death**

**Father \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mother \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Brothers/Sisters:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Your Children:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Personal History:**

What is your occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circle one: Married Single Divorced Widowed Other

Do you currently smoke? Yes No If yes, how many packs per day? \_\_\_\_\_\_\_\_\_\_\_

Have you smoked in the past? Yes No If yes, what year did you quit? \_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? Yes No If yes, how many drinks per week? \_\_\_\_\_\_\_\_

Do you use drugs? Yes No If yes, what drugs? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have an Advanced Directive or have you designated a Durable Power of Attorney for

Health Care? Yes No (If yes, please provide a copy for your health care provider.)

**Immunizations:** List the last year you had any of the following vaccinations.

Hepatitis A \_\_\_\_\_\_\_\_\_\_\_ Hepatitis B \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Shingles \_\_\_\_\_\_\_\_\_\_\_

Pneumonia \_\_\_\_\_\_\_\_\_\_\_ Tetanus \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Flu \_\_\_\_\_\_\_\_\_\_\_

**Procedures:** List the last year you had any of the following.

Colonoscopy\_\_\_\_\_\_\_\_\_\_\_ Eye exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cholesterol test \_\_\_\_\_\_\_\_\_\_\_\_\_

**For Women only:** List the number of Pregnancies \_\_\_\_\_Births \_\_\_\_\_ Abortions\_\_\_\_\_Miscarriages\_\_\_\_\_

List the year of your last Pap \_\_\_\_\_\_\_\_\_ Mammogram \_\_\_\_\_\_\_\_\_\_\_ Bone density test \_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Statesboro Family Practice

**Informed Consent to use Patient Portal**

Statesboro Family Practice is now offering this secure, HIPAA compliant tool as a courtesy to our patients. This is an optional service and we reserve the right to suspend or terminate it at any time, we will alert you to any changes as promptly as possible. By signing below, you confirm that you have **received, read, understand, and agree to comply with the “Procedures and Guidelines for using the Patient Portal”.**  You also agree not to hold Statesboro Family Practice or any staff liable for network infractions beyond their control.

**Privacy and Security** The patient portal has a secure tunnel connection with our clinic that uses encryption to keep unauthorized people from accessing your health information. To help ensure that our tunnel remains secure we ask that you provide us with your most current private email address and notify the office if it ever changes. Always keep your user ID and passwords secure so only you or someone you authorized can gain access to your information. If you think someone has learned your password, immediately notify our office so we can instruct you on how to change it.

Your email address is confidential and protected information. We will protect this information with our best effort as we do with all your medical and personal information.

**Procedures and Guidelines**

**Current functionality of Patient Portal:** ◾Email and secure messaging for non-urgent needs. ◾Refill request◾Viewing and printing of continuity of health record.◾Viewing and updating of health information.◾Viewing of selected health information (allergies, medications, current problems, past medical history). \* Note- You can make changes/additions to your health records, medication list, etc. but this will not change your permanent record without our review of the information.◾Appointment request◾Billing questions◾Updating your demographic information (address, phone # etc.) and updating insurance information.

**Lab results-** You can view copies of lab test results, and any explanations or comments from your provider. Your provider may decide that the results of your lab tests should not be published on the Patient Portal because they need to have more explanation than can be provided on the Portal. In this case, your provider will make other arrangements to discuss your lab test results.

**PLEASE NOTE: This patient portal does have the functionality of back and forth communication between patient and Clinic but should never be used in time sensitive matters, it may take up to 48 hours for response.**

**Confidential email (print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **(Each patient must have their own form, ie; mom + 4 children = 5 different forms)**

**Print Name of Parent/Guardian requesting access for minor child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Payment Policy**

Thank you for choosing **Statesboro Family Practice** as your primary care/urgent care provider. We are committed to providing you with quality and affordable health care. Because patients have had questions regarding patient and insurance responsibility for services rendered, we developed this financial policy to help answer the questions that you may have. Please read the policy below, ask any questions that you may have, and sign and date it in the designated space.

1. **Insurance**. We participate with most insurance plans, including Medicare. If you are not insured by a plan that we are contracted with, payment in full is expected at each visit. If you are insured by a plan that we contract with, but we cannot verify your coverage, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

**Note: If you are paying in full for services and we are not billing insurance, you may be eligible for a discount.**

1. **Co-payments and deductibles.** All co-payments and deductibles must be paid at time of service. This arrangement is part of your contract with your insurance company. We have a legal obligation as a contracted provider to collect deductibles and co-payments at each visit.
2. **Non-covered services.** Please be aware that some of the services you receive may be non-covered or not considered necessary by Medicare or other insurances. You must pay for these services in full at time of visit.
3. **Proof of insurance.** All patients must complete our patient form before seeing the provider. We must obtain a copy of your driver’s license or other photo identification card along with your current insurance card.
4. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claims is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.
5. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make appropriate changes to help you receive your maximum benefits. **If your insurance company does not pay your claim in 45 days, the balance will automatically be charged to your credit card or billed to you if we do not have a credit card on file.**
6. **Nonpayment.** If your account is more than 35 days past due, you will receive an automated phone reminder/statement that you have a balance due. If your account is more than 70 days past due, you will receive a second reminder/statement that you have a balance due.

After 70 days if your account is still past due, all future services will require your past due account balance to be paid in full as well as any services that you receive going forward. We will also require that a credit card be kept on file if we have not obtained one already.

If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Please be aware that if a balance remains unpaid, we may refer you to a collection agency and you may be discharged from this practice. If this is to occur, you will be notified that you have 30 days to find alternative medical care. During the 30-day period, our provider will only be able to treat you on an emergency basis.

1. **Missed appointments.** Our policy is to charge for missed appointments not canceled within 24 hours. These charges will be your responsibility and will be charged to your credit card or billed directly to you if we do not have credit card information on file. Please help us serve you better by keeping your regularly scheduled appointments.

**Note**: The current charge for missed appointments is $25 and the amount of the charge is subject to change without notice at any time.

Our practice is committed to providing the best possible care to our patients. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

**I have read and understand the payment policy and agree to abide by its guidelines:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of patient or responsible party Date of Birth Date**