1. PATIENT INFORMATION

Patient Name: ____

2. Date of Birth: ________________ Age: __________ Sex: ________

Address: ____

City: ____________________________ State: ____________ Zip: __________

E-Mail: ____

Home Phone: ( ) ______________________ Work Phone: ( ) ___________________

Cell Phone: (____________________

Social Security Number: ________________ Driver's License: __________________

Name & Address of Employer: ____

____

Marital Status: Married Single ___ Divorced Widowed

2. SPOUSE INFORMATION

Spouse Name: ____

Spouse Social Security Number: ____

Spouse Date of Birth: ____

Spouse Address: ____

Spouse Employer & Address: ____

Spouse Work Phone: Day Phone: ______________________

3. RESPONSIBILITY

Person Responsible for Account: ____

Relationship: ____

Address: ____

Work Phone: Day Phone: ______________________

Social Security Number: Driver's License: __________________

Employer: Occupation: ______________________

Employer's Address: ____

4. EMERGENCY INFORMATION

Person to contact in case of emergency: ______________________________

Phone: Relationship: ____________________

5. IF STUDENT, PERMANENT/PARENT'S NAME & ADDRESS:

____

Pharmacy: ____________________________________

Revised 01/01/2024

Insurance Information

As a courtesy to our patients, we will file your insurance claim at no charge; however this information must be complete.

6. INSURANCE INFORMATION

Primary insurance is through: Self ___ Spouse ___ Mother ___ Father ___

Name of Insured: ____________________ Social Security Number: __________________

Date of Birth: ____________________ Name of Insurance Company: ____________________

Group #: ____________________ ID#: ________________ Policy #: ____________________

Billing Address: ____

Phone Number: ____

7. MEDIGAP (SECONDARY INSURANCE)

Name of Beneficiary: ____

Health Insurance Company: ____

Medigap Policy Number: ____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Elite Primary Care may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Elite Primary Care'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.

Elite Primary Care reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer, Elite Primary Care. 1720 Reynolds Street, Waycross, Georgia 31501.

With my consent, Elite Primary Care may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others.

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

With my consent, Elite Primary Care may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Elite Primary Care restrict how it uses or discloses my PHI to carry out TPO.

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

By signing this form, I am consenting to Elite Primary Care'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, Elite Primary Care may decline to provide treatment to me.

______________________________ ______________________

Signature of Patient or Legal Guardian Date of Birth

____

Patient's Name Date

____

Print Name of Patient or Legal Guardian

Elite Primary Care may discuss my medical condition/ information with the following:

Name of Person: Relationship:

____

Person to contact in case of emergency:

____

Name **Phone**

Revise 01/01/2024

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Payment is due at the time of service. We accept Cash, Personal Checks, Visa and MasterCard
   If you are a new patient: We require that your first visit be paid by Cash, Visa or MasterCard.
2. Keep in mind that your Insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor – in other words, if you agree to have your insurance pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you. We have made prior arrangements with many insurance companies and health plans to accept an assignment of benefits. We will bill them, and you are required to pay a copayment or percentage at the time of your visit.
3. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you. Our charges for your care are due at the time of service. If the insurance carrier sends the office a check, we will in return send you a refund check.
4. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from out office.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_______________________________________ _______________________

Signature of Patient (or responsible party, if minor) Date

____

Please print name of the patient

IF YOU MISS AN APPOINTMENT WITHOUT CALLING TO RESCHEDULE OR CANCEL YOU WILL BE CHARGED A $50.00 NO SHOW FEE

ALL RETURN CHECKS HAVE A $25.00 RETURN FEE

Revised 01/01/2024

Narcotic Agreement and Refill Policy

This is an agreement between ____
and Elite Primary Care.

Pain management is an individual process. A plan that works for one person can be different for that of another. As part of our treatment, our physicians may prescribe narcotic medications for you. Many of these medications may have serious side effects if not taken properly. It is your responsibility to understand the prescribed medication regimen, take medicines only as directed, and communicate their effectiveness to our provider. Your health and safety are important to us, and we need your help in following our guideline. If we have any questions or concerns regarding your healthcare, including medications, we reserve the right to contact your other treating physicians and pharmacies. Please review and sign below:

- I agree to follow the dosing schedule prescribed to me by my doctor.
- I agree to never share my medications with others, nor will I sell or exchange my medications for any reason.
- I agree to notify my doctor if I experience any adverse effects or dosage problems with my prescribed medications.
- I agree that if I receive any narcotic prescriptions from prescriber, I am not allowed to receive the same type of medications or other narcotics from another physician without consent from my prescriber. This includes ER visits. Before accepting and narcotic medicine from other physician, I will ask that physician to contact prescriber for approval.
- I agree to be evaluated at regular intervals for continuous narcotic treatment as advised by the medical staff or prescriber.
- I agree to use only one pharmacy, which is ___________________________________ for my pain related medications unless extenuating circumstances prevent this from being possible. In this event, I will notify prescriber of all information pertaining to additional pharmacies, mail-order, or other sources.
- I agree to bring medications I am currently taking to each appointment and/or procedure with prescriber. This includes all prescription medications, vitamins, and herbal supplements.
- I understand that I should not drive or operate heavy machinery while I am taking medications that mat effect my cognitive function and/or cause drowsiness.

- I understand that I am solely responsible for the safekeeping of my medications and I must treat my medications as I would my money or valuable possessions. Under NO circumstances will prescriber replace lost or stolen prescriptions or medications.

- In the event that my physician feels that my dose of pain medication is excessive or makes the diagnosis of addiction, he/she will reduce the medicine over a period of time as necessary to avoid withdrawal symptoms. A drug-dependence treatment or detoxification program may be recommended.

- I understand that abusive behavior or harassment toward any provider or staff will not be tolerated.

- I understand that dealing with a forged or falsified prescription will result in immediate dismissal from prescriber.

- Prescription Refills – You must call 3-5 business days before your medication runs out during office hours only. You must call to request the refill yourself and the staff will ask questions to establish your identity. Pain medication prescriptions are written in 30 days supplies and will be filled on the same day every month unless this date falls on a weekend or holiday.

- Prescription Pickups – Once the refill has been approved by the doctor or provider, they will be available for pickup. Only the patient may pick up the prescription and the staff will request a photo ID. We will not mail any pain medication prescriptions.

- I understand that prescriber will require me to submit to a urine drug screen at random intervals. If my screen tests positive for unprescribed substances, illicit drugs, or is negative for medications that I have been prescribed, I understand that this is possible grounds for dismissal from the practice. If the physician feels a repeat drug screen is indicated, I understand that I may be responsible for the payment of this test if denied for payment by my insurance company.

By signing this agreement, you affirm that you have the full right and power to be bound by this agreement and that you have read, understood, and accepted these terms. NO pain medications will be prescribed without the acceptance of this agreement.

Patient Signature: ______________________________ Date:__________

Patient Account #: ______________________________ Date:__________

Witness Signature: ______________________________ Date: __________

Medical History

Name: ____ Date: ____________

1. Check all the following that you have or have had:

__ Glaucoma	__ Rheumatic Fever	__ Bleeding Problems	__ Breast Problems
__ Hearing Loss	__ High Cholesterol	__ Inflammatory Bowel	__ Kidney Problems
__ Thyroid Problems	__ Stomach Problems	__ Poor Circulation	__ Lumps or Bumps
__ Hormonal Problems	__ Trauma	__ Arthritis	__ Headaches
__Pneumonia	__ Gallbladder Probs.	__ Varicose Veins	__ Migraines
__ Emphysema/COPD	__ Hiatal Hernia	__ Skin Growths	__ Angina
__ Asthma	__ GI Bleed	__ Abdominal Pain	__ Seizures
__ Tuberculosis	__ Colon Polyps	__ AIDS	__ Skin Problems
__ High Blood Pressure	__ Hepatitis	__ Herpes	__ Psoriasis
__ Heart Attack	__ Hernias	__ Venereal Disease	__ Cancer
__ Abnormal Pap	__ Hemorrhoids	__ TMJ Problems	__ Blood Transfusion
__ Ob/Gyn Problems	__ Diabetes		

Additional Remarks:

____

____

____

2. Please list all previous surgeries:

__ Hernia Surgery	__ Pediatric Surgery	__ Hand Surgery	__ Gallbladder Surgery
__ Lung Surgery	__ Heart Surgery	__ Foot Surgery	__ Vascular Surgery
__ Kidney Surgery	__ Appendectomy	__ Tonsillectomy	__ Colon Surgery
__ Surgery for Bowel Obstructions	__ Surgery for Trauma	__ Laparoscopic Surgery	__ Hysterectomy or Ovary Surgery
	__ Vasectomy		
__ Tubal Ligation	__ Cancer Surgery	__ Testicular Surgery	__ Ob/Gyn Surgery
__ Breast Surgery	__ Skin Cancer Surgery	__ Head and Neck	__ Cosmetic Surgery
__ Plastic Surgery		__ Ear Surgery	__ Eye Surgery

Additional Remarks:

____

____

____

3. Family history (Check all that apply):

__ Heart Disease	__ Migraine	__ Hyperlipemia	__ Diabetes
__ Stroke	__ Cancer	__ High Blood Pressure	

Additional Remarks:

____

____

____

4. Do you smoke (circle)? Yes No If "Yes", how many packs per day? Number of years? ___
   Do you drink (circle)? Yes No If "Yes", how many packs per day? Number of years? ___

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5. Do you have allergies to any medications? Yes No If "yes" please list

____

6. Review of Systems (Check al that apply:)

Constitutional Systems:		**Cardiovascular:**		**Gastrointestinal:**		**Musculoskeletal:**	
Have you had recent fever?		Do you have a heart murmur?		Poor Appetite?		Physically Handicapped?	
Have you had recent chills?		Do you have heart disease?		Heart Burn?		Muscle Problems?	
Have you had constipation?		Chest pressure, tightness, or pain?		Nausea or Vomiting?		Joint Problems?	
Have you had recent weight loss?		Palpitations?		Vomiting blood or coffee ground type material?		Trouble with walking?	
Have you had diarrhea?		Skipped beats?		Stomach Pain?		Neck Problems?	
Ears, Nose, Mouth, Throat:		Leg pain when walking?		Ulcers?		**Skin:**	
Nosebleeds?		Blood clots or inflammation in leg veins?		Liver disease or Jaundice?		Moles that are changing?	
Hoarseness?		Varicose Veins?		Gallstones?		Moles with different colors?	
Swallowing Problems?		Swollen ankles or feet?		Change in bowel habits?		Moles with Irregular borders?	
Mouth Problems?		Fainting?		Pancreas Problems?		**Neurological:**	
Ear Problems?		Do you sit up to sleep?		Black or tarry stools?		Fainting?	
Eyes:		Out of breath quickly?		Do you use enemas or laxatives?		Numbness anywhere?	
Do you wear Contacts or Glasses?		Bleeding problems?		Greasy Frothy Stools?		Convulsions or Seizures?	
Vision Changes?		**Respiratory:**		Rectal pain, burning?		Tremors?	
Blurred Vision?		Do you have a cough?		**Genitourinary**		Paralysis or weakness?	
Double Vision?		Productive cough?		Prostate Problems?		Coordination Problems?	
Eye Surgery?		Cough blood?		Menstrual Problems?		Stroke?	
Episodes like a window shade coming over your eyes?		Wheezing?		Vaginal Discharge?		**Psychiatric:**	
Hematology/Lymphatic:		Breathing problems?		Testicular pain or swelling?		Do you have a mental disorder or disease?	
Do you have a blood disorder?		**Allergic/Immunologic:**		Sexual Problems?		Do you have mood swings?	
Do you or have you ever had abnormal or enlarged lymph nodes?		Do you have any allergic conditions?		Penile Discharge?		Do you suffer from depression?	
Have you ever had Lymphoma or Leukemia?		Do you have any immunological conditions?		Impotency?		Do you or have you ever had an alcohol problem?	
Are you taking any blood-thinning pills?		Do you have a skin rash?		Do you have any urinary or bladder problems?		Do you or have you ever had a drug problem?	

7. Please list your current medications including the amount you take each day (dosage), how you take this medication (route), and the number of times you take this medication each day (frequency):

Name of Medication	Amount (milligrams)	How is it given? (Mouth, Injection or Skin Patch?)	How many times a day do you take this medication?

We appreciate your cooperation so that we may continue to provide the best medical care for you!