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WOODS MEDICAL, LLC

Patient Registration Form

1. Patient Information

Please Circle: Dr. ◯ Mr. ◯ Mrs. ◯ Ms. ◯ Jr. ☐ Sr. ☐ Male ◯ Female ◯

Patient's Name: (Last) _____ (First) _____ (Middle) _____

Address: _____

City, State, Zip: _____

SS#: _____ DOB: _____ Email: _____

Race: White ☐ African American ☐ Hispanic ☐ Asian ☐ Other ☐

Ethnicity: Non-Hispanic ◯ Hispanic ◯ Refuse to report ◯

Marital Status: Married ◯ Single ◯ Divorced ◯ Widowed ◯ Legally Separated ◯ Other ◯

Language: English ◯ Other ◯

Phone Numbers: Home _____ Cell _____ Work _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone Number _____

Local Pharmacy: _____ Mail Order Pharmacy: _____

Are you the primary party with regard to your insurance? _____ Yes _____ (If NO, please continue to section #2)

2. Responsible Party Information (If Different From Patient)

Name: (Last) _____ (First) _____ (Middle) _____

Address: _____ City: _____ State: _____ Zip: _____

SS#: _____ DOB: _____ Relationship to Patient: _____

Phone Number: _____

PLEASE NOTE: OUR OFFICE MUST HAVE A COPY OF YOUR CURRENT INSURANCE CARD OR FULL PAYMENT WILL BE DUE AT TIME OF SERVICE.

Photo Authorization

I authorize Woods Medical, LLC to use my photo as part of my protected health record for identification and treatment purposes only.

Patient, Parent, or Guardian _____ Date _____

Financial Policies

It is the policy of this office to pay for services in full when rendered. If this applies to you, we will file your claim and you will be expected to pay what the insurance company does not pay. In case of any of the above named companies or individuals fail to make prompt payment, I hereby give my personal Guarantee of Payment for all charges herein, incurred. If this account is placed with an attorney for collection, the undersigned parties agree to pay all reasonable attorney fees, as well as costs of collection. I hereby authorize my insurance benefits to be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information for the processing of the claim.

Patient, Parent, or Legal Guardian_____Date_____

Privacy Statement

We consider any information that concerns your health, health care, or payment for that care to be confidential and protected information. The privacy notice describes our privacy practices, specifically how we use and disclose your medical information and what right you have with respect to this information. We require all of our employees, staff and independent contractors to comply with these privacy practices. We are required by federal law to obtain acknowledgement from you that you have received this notice. By signing below, you are acknowledging that you have received a copy or have had access to a copy of our Privacy Statement.

Signature: _____Date:_____

HIPAA PRIVACY RULE

Please list the parties to whom you authorize Woods Medical, LLC to disclose your protected health information.

I hereby authorize the release of my medical records (including all patient records, office notes, x-rays and lab results) to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Missed Appointments

Our office charges a $25 fee for missed appointments without a phone call or internet message to cancel at least 24 hours before your appointment time. This must be paid in full prior to being seen again in our office.

Initials_____

Prescription Refills

- If you get your prescriptions filled at a pharmacy, **PLEASE CALL YOUR PHAMACY OR USE THE PATIENT PORTAL FIRST** with your refill request (the pharmacy will fax us your order).
- Please allow 2 days for prescription requests to be processed.
- DO NOT WAIT UNTIL YOU ARE OUT OF MEDICATION TO CALL.
- If you have an appointment with us that is the BEST TIME to discuss refills.

Initials_____

Returned Checks:

All returned checks will incur a $30 billing fee. The patient will be responsible to pay this in full before services can be rendered again by this office. This includes some prescription refills.

Initials_____

Lab/Test Results:

You will receive your results by mail or by phone call. If you have not heard from our office within 2 weeks of having your labs drawn or test done, please contact our office.

Initials_____

Woods Medical, LLC

PATIENT HISTORY FORM:

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

Name: _____

DOB: ___Month___/___Day___/___Year_____ **Age:** _____

Date of Last Physical Exam: _____/_____/_____

Current Complaints:

_____

_____

_____

MARK IF YOU HAVE HAD ANY PROBLEMS BELOW:

GENERAL

- ☐ Weight loss
- ☐ Fever
- ☐ Chills
- ☐ Fainting
- ☐ Sweats

GASTROINTESTINAL

- ☐ Poor appetite
- ☐ Bowel habit changes
- ☐ Indigestion
- ☐ Stomach pain
- ☐ Bloating
- ☐ Belching
- ☐ Gas
- ☐ Constipation
- ☐ Nausea
- ☐ Excess hunger/thirst
- ☐ Hemorrhoids
- ☐ Diarrhea
- ☐ Rectal Bleeding
- ☐ Vomiting

MUSCLE/JOINT/BONE-ACHING

- ☐ Arms
- ☐ Hips
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Shoulders
- ☐ Neck

EAR/NOSE/THROAT

- ☐ Vision Changes (double or blurry)
- ☐ Allergy/sinus problems
- ☐ Cough
- ☐ Ear pain
- ☐ Difficulty swallowing
- ☐ Ringing in ears

URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Urinary incontinence
- ☐ Painful urination

Skin

- ☐ Easy bruising
- ☐ Change in moles
- ☐ Rash
- ☐ Non-healing sore
- ☐ Itching

Men Only

- ☐ Breast lump
- ☐ Erectile difficulties
- ☐ Penile drainage
- ☐ Penile sore
- ☐ Lump in testicles

CARDIOVASCULAR

- ☐ Chest pain
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ High blood pressure
- ☐ Swollen ankles
- ☐ Irregular heart beat
- ☐ Varicose veins

Women Only

- ☐ Abnormal pap
- ☐ Breast lump
- ☐ Menstrual pain
- ☐ Painful intercourse
- ☐ Nipple discharge
- ☐ Hot flashes
- ☐ Irregular periods

CURRENT PRESCRIPTION MEDICATIONS

Name of Drug	mg/Dose	# tablets	# times per day

OVER THE COUNTER MEDICINES

(Aspirin, Tylenol, Ibuprofen, Aleve, vitamins and herbals)

Medical Conditions

(High BP, Diabetes, Asthma, Cancer, etc)

Allergies

Surgeries

Hospitalizations

Family History

Father: If living-Age: _____ If deceased, age at death: _____ Cause: _____

Mother: If living-Age: ____ If deceases, age at death: _____ Cause: _____

Siblings: Number_____ Living_____ Deceased_____ Cause(s): _____

List other illnesses in your family (Example- Diabetes, heart disease, cancer, etc)

Family Member	**Illness**	**Family Member**	**Illness**

SOCIAL HISTORY

- # of alcoholic beverages daily_____
- Do you use tobacco? *Yes*◯_____ *No*◯_____ If YES, how much? _____
- Last mammogram: _____
- Last bone-density scan: _____
- Last colonoscopy: _____
- Last tetanus_____ Last flu shot _____
- Last pneumonia vaccine_____
- Last shingles vaccine_____

Do you see any specialists?

_____ _____

_____ _____

_____ _____

CENTRAL GEORGIA HEALTH EXCHANGE

The next generation of patient information

Permission to Create a *Health Exchange record* and Share My Medical Information with my Healthcare Providers

We are taking part in an exciting program to improve your healthcare and make office visits easier and more convenient. To do this, all of your doctors participating in the Central Georgia Health Network (CGHN) would like your permission to share your Health Information (as defined below) through the *Central Georgia Health Exchange* electronic medical record program (*Health Exchange*). This will authorize your CGHN-participating doctors to disclose your Health Information so that it can be shared electronically with other providers of healthcare to you.

I acknowledge that I have read the information set forth below and understand the permission I am giving in this document, and have had the opportunity to have my questions answered about the *Health Exchange and this* permission form.

☐ Yes, I agree to participate in the Central Georgia Health Exchange electronic medical record

☐ No, I do not agree to participate in the Central Georgia Health Exchange electronic medical record

Printed Name of Patient/Representative	*Signature of Patient/Representative*	*Date*

AUTHORITY OF REPRESENTATIVE:

I, _____, do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis (Relationship to Patient): _____

[A signed copy of this permission will be provided to the patient/representative]

This authorization will allow your CGHN-participating doctors to disclose your demographic, insurance, and medical information so that it can be shared with other providers of healthcare to you (including doctors, nurses, and other health professionals, as well as hospitals and other healthcare facilities) and CGHN, through the *Health Exchange* electronic medical record system. Only authorized healthcare providers and their contractors, and others whose job it is to maintain, secure, monitor and evaluate the operation of the information system and quality of care, would be able to access your information. The *Health Exchange* will allow your providers access to your health information more quickly and accurately than with paper charts.

By signing this authorization, I authorize all of my doctors who participate in CGHN to use and disclose my Health Information and to make such Health Information available through the *Health Exchange* to other healthcare providers who need access to my Health Information for the purposes described in this document. The Health Information may include, but is not limited to the following: Information contained in medical records; physicians' records; surgeons' records; x-rays, CAT scans, MRI films, photographs, or other radiological, nuclear medicine or radiation therapy films; pathology materials, slides or tissues; laboratory reports; genetic testing results; discharge summaries; progress notes; consultations; prescriptions; records of child abuse, spousal abuse, drug abuse and alcohol abuse; HIV/AIDS and sexually transmitted diseases diagnosis or treatment; physicals and histories; nurses' notes; patient intake forms; correspondence; social workers' records; insurance records; consents for treatment; and any other documents concerning any treatment, examination, periods of hospitalization, confinement, diagnosis or other information concerning my physical or mental condition.

Information disclosed pursuant to this permission may no longer be protected by federal health information privacy laws and may be subject to redisclosure. However, the *Health Exchange* system incorporates access controls, encryption technology and other security features designed to protect the privacy and security of your Health Information. In addition, access to the *Health Exchange* will be limited to only those users who have agreed to use the *Health Exchange* consistent with your permission. Information shared through the *Health Exchange* will be used and disclosed for the following purposes and disclosures: clinical care; obtaining reimbursement for health care services; ; for administrative functions related to the provision of and payment for care; quality monitoring and improvement; and administrative management of the *Health Exchange* and CGHN.

You can learn more about the *Central Georgia Health Exchange* by reading the information booklet, "A Guide To The Central Georgia Health Exchange" that is available at the CGHE website (https://www.CGHE.net) or on request from your doctor's office.

I understand that I may withdraw this permission by giving written notice to Administrator, Central Georgia Heath Exchange, 777 Hemlock Street, Hospital Box 98, Macon, GA 31201. Any withdrawal of permission will be effective except to the extent action already has been taken in reliance on this permission. This permission will expire automatically if the *Central Georgia Health Exchange* program is discontinued.

I understand that my eligibility for treatment or any healthcare benefits cannot be conditioned on whether I sign this permission. However, to the extent I have refused permission, I understand that my Health Information will not be available to other providers (including The Medical Center of Central Georgia) through the *Central Georgia Health Exchange*.

W. Jason Woods, MD, LLC

PO BOX 26460

(478)755-0020 FAX (478)742-5000

RELEASE OF MEDICAL RECORDS

Patient Name_____**Date**_____

Date of Birth_____**SSN** _____

Patient Address_____

_____

I hereby authorize the release of my medical records to:

(Including all inpatient records, office notes, x-rays, and lab results)

Dr. W. Jason Woods
Mail: 220 North Macon Street
Macon, GA 31210
(Or to the PO Box listed above)
Fax: (478)-742-5000

CONSENT TO DISCLOSE MEDICAL INFORMATION

I_____, am granting permission to allow the following people to have access to my medical and accounting records. I understand that I may revoke this consent by completing a new consent form.

Signature of Patient:_____

Spouse:_____

Parent:_____

Child:_____

Legal Guardian:_____

Other:_____