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: _____

Marital Status: Married: ☐ Single: ☐ Divorced: ☐ Widowed: ☐ Legally Separated: ☐ Other: _____

Phone Numbers: Home: _____ Cell: _____ Work: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Relation: _____ Phone Number: _____

Pharmacy: _____ Pharmacy Location: _____

Are you the primary with regard to your insurance? _____ (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: _____ Relation 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 protect 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 $40 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 PHARMACY 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 offices 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: _____/_____/_____ **Age: _____**

Date of Last Physical Exam: _____/_____/_____

_____

Current Complaints:

_____

_____

_____

Mark If You Have Had Any Problems Below:

General
- ☐ Weight Loss
- ☐ Fever
- ☐ Chills
- ☐ Fainting
- ☐ Sweats

Muscle/Joint/Bone-Aching
- ☐ Arms
- ☐ Hips
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Shoulders
- ☐ Neck

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

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

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

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

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

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

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)

Medial Conditions

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

Allergies

Surgeries

Hospitalizations

Family History

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

Mother: If living – Age: _____ If deceased, 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 _____

Do you see any specialists?

_____ _____

_____ _____

_____ _____

Financial Policy for Woods Medical, LLC - Dr. W. Jason Woods

1. You are ultimately responsible for payment of services rendered from our office. Please contact your insurance to confirm coverage AND benefits. We can NEVER guarantee coverage for any service provided by our office. You are responsible for any balance that is left after all insurance payments and contracted adjustments are applied.
2. It is your responsibility to provide us with your current address, telephone number and insurance information at each visit. IT IS REQUIRED THAT YOU PRESENT YOUR INSURANCE CARD(S) TO US AT EVERY VISIT.
3. It is your responsibility to contact your insurance company to confirm that our physicians participate with your plan.
4. ALL COPAY, BALANCES, AND DEDUCTIBLES ARE DUE AT EVERY VISIT UNLESS PRIOR PAYMENT ARRANEMENTS ARE MADE. WE DO NOT ACCEPT CHECK FOR COPAYS/BALANCES/ DEDUCTIBLES IN THE OFFICE UNLESS IT IS MAILED IN FROM A STATEMENT.
5. If you miss your appointment you will be charged $40 no-show fee for each appointed missed. There is also a $40 fee if you do not cancel 24 hours in advance.

***You will receive your EOB in the mail approximately 10-21 days after your visit. Please OPEN and read what the patient responsibility is (minus what you have prepaid). You are welcome to call in with a payment or check your portal for a copy of our statement along with the capability of paying your balance thru the portal. STARTING WITH THE 2ND STATEMENT THAT IS MAILED OUT THERE WILL BE A POSTAGE/LATE FEE THAT WILL BE YOUR RESPONSIBILTY TO CALL AND CHECK. THESE CAN GET LOST IN THE MAIL.

6. ALL BALANCES OVER 30 DAYS (AFTER RECEIVING 1 STATEMENT) WILL BE ASSESSED A LATE CHARGE OF $10 A MONTH UNTIL THE BALANCE IS PAID UNLESS YOU ARE ON A PAYMENT PLAN.
7. If your account is OVER 60 DAYS (AFTER RECEIVING 2 STATEMENTS) your account will be considered delinquent and immediate payment in full will be required. Partial payments will not be accepted unless otherwise negotiated.
8. If your account is NOT PAID WITHIN 90 DAYS it will be sent over to Creditors Bureau Associates/Collection Agency. You will then be responsible for a 30% fee added to your balance turned over to them. WE MAY INCLUDE ADDITIONAL CREDIT BUREAU FEES/ATTORNEY/COURT FEES IF NECESSARY.
9. PATIENTS WITH ACCOUNTS IN BAD DEBT WILL NOT BE ALLOWED TO SCHEDULE FURTHER APPOINTMENTS AT OUR OFFICE UNTIL THE ACCOUNT BALANCE IS PAID IN FULL. PATIENTS WITH ACCOUNTS HAVING A HISTORY OF NON PAYMENT ARE SUBJECT TO BEING DISMISSED FROM THIS PRACTICE.

ADMINISTRATIVE SERVICE FEES:

*THERE WILL BE NO CHARGE FOR BIOMETRIC FORMS BROUGHT ON THE DAY OF YOUR PHYSICAL EXAM! OTHERWISE, IT WILL BE $10.00 TO FILL OUT THE BIOMETRIC FORM.

*COMPLETION OF FORMS: $50.00 (FMLA, DISABILTY, OTHER 3RD PARTY FORMS)

*FORMS REQUIRING NOTARY: $10.00 *MISCELLANEOUS FORMS/LETTERS: $15.00

*MEDICAL RECORDS (PLEASE ASK–THE COST IS PER PAGE, PLUS A BASE FEE FOR COPYING AND RETRIEVAL)

I HAVE READ AND FULLY UNDERSTAND THE TERMS OF THIS AGREEMENT AND THE PRACTICE FEE SCHEDULE.

Printed Name: _____ Signature: _____ Date: _____

Woods Medical, LLC

PO BOX 26460

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

RELEASE OF MEDICAL RECORDS

Patient Name: _____ Date: _____

Date of Birth: _____ SS#: _____

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

<u>Mail:</u> 220 North Macon Street

Macon, GA 31210

(Or to the PO Box listed above)

<u>Fax:</u> (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: _____