WOODS MEDICAL
Internal Medicine

PATIENT INFORMATION:			
Last Name:	First Name:	MI:	Marital Status (check one): ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Widowed
Mailing Address:			Race (check one): ( ) Black/African American ( ) White ( ) Hispanic ( ) Other
City:	State:		Zip Code:
Email:	Cell Phone: (Primary) ( )		Home Phone: (Alternate) ( )
Date of Birth:	Sex: (check one): ( ) Male ( ) Female		Social Security Number: xxx - xx - xxxx
Employer:	Occupation:		Employer Phone: ( )

IN CASE OF EMERGENCY:			
Name:	Relationship to Patient:	Cell Number: ( )	Home Number: ( )

HEALTH INFORMATION DISCLOSURE: (HID)

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:

( ) Check if you DO NOT want your emergency contact or anyone else to have HID access

Name / Phone Number:	1. /	2. /
3. /	4. /	

INSURANCE INFORMATION		
1. **Name of Primary Insurance:**		Subscriber's SSN: (if different from patient)
Subscriber's Name: (if different from patient)		Subscriber's DOB: (if different from patient)
ID/Policy Number:		Group Number/Plan Code:
Patient's Relationship to Subscriber: ( ) Child ( ) Self ( ) Spouse ( ) Other		
2. **Name of Secondary Insurance:**		Subscriber's SSN: (if different from patient) XXX-XX-XXXX
Subscriber's Name: (if different from patient)		Subscriber's DOB: / / (if different from patient)
ID/Policy Number:		Group Number/Plan Code:
Patient's Relationship to Subscriber: ( ) Child ( ) Self ( ) Spouse ( ) Other		
3. **Other Insurance:**	ID/Policy Number:	Group Number/Plan Code:

The above information is true to the best of my knowledge. I hereby authorize direct payment to my physicians from my insurance company when applicable. I understand that I am responsible for any balance(s) not paid by my insurance carrier and is to be paid to Woods Medical. Said balance is to be paid. I also authorize the release of any medical information to a referring physician or insurance company

Patient/Guardian Signature: _____ **Date:**

Patient Name: _____ Date

Age _____ DOB Date of Last Physical

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 hunger/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

Family History

Father: If living – Age:	If deceased, age at death:	Cause:
Mother: If living – Age:	If deceased, age at death:	Cause:
Number of siblings living:	Number of siblings deceased:	Cause:
Number of children:_____ Number of Male(s): _____ Number of Female(s): _____ Are children healthy?: ( ) yes ( ) no		

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

Family Member	Illness	Family Member	Illness

Patient Name: _____ DOB:

Patient History (fill in health information about yourself)

Current Prescriptions Medications

Name of drug	Dosage	# of tablets	# times taken per day	Prescribing physician

( ) Please check box if unable to tolerate statins

Current OTC Medication (this includes vitamins and Herbal treatments)

Name of drug	Dosage	# of tablets	# times taken per day	Prescribing physician

Allergies (reaction-hives, swelling, nausea/type-allergy, side effect, lack of therapy/status-active, inactive)

Name of Drug/Food	Reaction	Type	Status

Medical Conditions

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

Allergies

Surgeries

Hospitalizations

Patient Name: _____ DOB:

Check if, your blood relative had any of the following:

Disease	Relationship to you	Vaccine	Date Given
( ) Arthritis, Gout		( ) Tetanus/Tdap	
( ) Asthma, Hay fever		( ) Pneumovax (pneumonia)	
( ) Cancer		( ) Flu	
( ) Chemical Dependency		( ) Gardasil (HPV)	
( ) Diabetes		( ) Varicella (chicken pox)	
( ) Heart Disease		( ) Meningococcal	
( ) High Blood Pressure		( ) Hepatitis A	
( ) Kidney Disease		( ) Hepatitis B	
( ) Tuberculosis		( ) Zostavax (shingles)	
( ) Stroke		( ) Prevnar 13	

Social History

Number of alcoholic beverages daily _____
Last Mammogram: _____
Last Colonoscopy: _____
Last Flu Shot: _____
Do you exercise?: _____

Do you use tobacco? ( ) no ( ) yes – How much? _____
Last bone-density scan (DEXA): _____
Date of last hemoglobin A1c: _____
Covid shot: _____ Brand: _____ # of shots: _____

List any specialists you are currently seeing:

List any medical problems you have had in the past:

List any current problems you would like to address with the provider today:

I certify that the information above is correct and completed to the best of my knowledge.

Patient Signature: _____ **Date:**

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Patient Financial Policy

W. Jason Woods, MD

Unless other arrangements have been made in advance with the office manager;

- All co-pays and deductibles are due at the time of the visit.
- Additional financial responsibility may be determined after your insurance has processed your claim.
- For your conveniences we accept Visa, MasterCard, Discover, American Express and Cash.
- Checks returned for NSF will incur a $30.00 fee which will be added to our account balance.

Patient Insurance

We have contracted with your insurance to accept assignment of benefits. You are responsible for any balance that is left after all insurance payments and contracted adjustments have been applied. If your health plan determines a service to be "not covered," you will be responsible for the complete charge. Should any test performed result with any abnormalities, additional testing may be required-and will fall under the patients' responsibility for those charges.

Self-Pay Patients

For all services rendered to patients without insurance or proper proof of insurance, a self-pay discounted charge will be applied to your account. Payment is due at the time of services rendered unless previous arrangements have been made with the billing office.

Account Balance

All patient balances must be paid in full after receiving a statement. All balances over 30 days (after receiving 1 statement) will be assessed a late charge of $10.00 a month until the balance is paid unless you are on a payment plan. All accounts 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.
If your account is not paid within 90 days, it will be turned over to Creditors Bureau Associates/Collection Agency. There will be an additional fee of 30% that will be added to the balance once turned over to the collection agency. We may include additional credit bureau fees/attorney/court fees if necessary.

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 for dismissal from the practice.

Patient Agreement:

I have read and fully understand the financial policy of the practice, and I agree to the terms listed above. I also understand and agree that the practice may amend such terms from time to time.

Patient Name Printed: _____ DOB:

Patient/Responsible Party Signature: _____ Date:

Policy effective date: 2021/11/04

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Missed Appointment policy & Fee Schedule

W. Jason Woods, MD

Each time a patient misses an appointment without providing proper notice another patient is prevented from receiving care. Our system is set to call, text or email you reminders of your scheduled appointment. Due to high patient demand and limited availability of appointments we have instituted a "missed appointment" fee.

You must give 24-hour advance notice to cancel or reschedule appointments; failure to do so will result in a "missed appointment" fee charge of $50 to your account. This includes no-shows or same day cancellations.

The following fees are billed directly to the patient and are not covered by insurance. These fees are administrative fees, and must be paid at the time the request is made.

There is no charge for biometric forms brought on the day of your physical exam.

- FMLA paperwork: $50.00 (This is a 7 – 10 day process time)
- Disability Forms: $25.00 (This is a 7 – 10 day process time)
- Handicap Parking permits/Notary: $10.00
- Medical Records in accordance with GA Laws O.C.G.A 31-33-3

Privacy Statement

We consider any information that concerns your healthcare or payment for services 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.

Prescription Refills:

The best time to discuss refills is at your routine scheduled appointments

- If you get your prescriptions filled at a pharmacy, PLEASE CALL YOUR PHARMACY or use the patient portal with your refill request (the pharmacy should escribe us your order)
- Please allow 2 days for prescription requests to be processed
- DO NOT WAIT UNTIL YOU ARE OUT OF MEDICATION TO CALL for refills

Lab/Test Results:

After the provider has reviewed your lab results, you will receive a call from one of our nurses. Please allow the full 2 weeks for your provider to review your labs before calling to check the status. If you have not heard from our office within 2 weeks of having your labs drawn or test done, please contact our office or send a message through your patient portal. After the nurse goes over your lab results with you over the phone, they will be posted to your patient portal for future review.

Patient/Responsible Party Signature: _____ Date:

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W. Jason Woods, MD

Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/facility listed below.

Patient Name: _____ DOB:

Records being requested from:

Dr. _____ Phone Number: _____ Fax Number: _____

Dr. _____ Phone Number: _____ Fax Number: _____

Dr. _____ Phone Number: _____ Fax Number: _____

The information you may release subject to this signed release form is as follows:

( ) Complete Records (last 2 years)
( ) Progress Notes
( ) H&P
( ) Other (Please specify below)
( ) Lab Reports
( ) Radiology Report
( ) Rx Records
( ) Pathology Reports
( ) Immunization Records
( ) Hospital Reports

(ONLY if this applies to you)

HIV/AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records. If this applies, please initial and date this form.

Signature: _____ Date:

Please release my protected health information to the following physicians/person/facility/entity and/or those directly associated in my medical care:

Name of facility releasing records to: _____

Address: _____

Phone #: _____ Fax#: _____

Release my protected health information to the following physician/facility:

W. Jason Woods, MD
Woods Medical Internal Medicine
220 North Macon Street, Macon, Ga 31210

Phone: 478-755-0020
Fax: 478-742-5000

Patient Name (Please Print): _____ Date:

Patient/Responsible Party Signature: _____ Date: