



Internal Medicine

Date _____

Name _____ Birth date _____

Why are you here today? _____

What causes it _____

When did it start _____ Severity _____
(Date) (scale of 1 - 10; 10 being most severe)

Location _____ Character _____
(Where do you feel the problem) (ie.; Sharp, dull, aching, pressure, racing etc)

Duration _____ How often _____
(Amount of time-minutes/hours it lasts) (# of times day/week/month)

Modifying factors _____
(What makes it worse and what makes it better)

Associated signs/symptoms _____
(Symptoms that consistently occur with the problem i.e.; nausea, shortness of breath)

Have you seen another Physician in regards to this problem? _____
If yes, whom? _____ When? _____

Have you ever been to a Cardiologist before? _____
If yes, when? _____ Why? _____

RISK FACTORS

- Has any of your immediate family (i.e. Mother, Father, or siblings) had Heart Disease before the age of 65? _____ If yes, please list whom, the problem, and the age that it occurred. _____
- Do you have high blood pressure? _____ How many years? _____
- Do you have diabetes? _____ How many years? _____
- Do you have high cholesterol? _____ How many years? _____ What was your level? _____
When was it completed? _____ Are you being treated and how? _____ (Diet, Exercise, Medication)
- If you are female have you had any surgical procedure removing your ovaries? _____
When was your last monthly period? _____

PAST MEDICAL HISTORY (Do you or have you had any of the following?)

Heart Attack	<input type="checkbox"/> No <input type="checkbox"/> Yes	Heart Murmur	<input type="checkbox"/> No <input type="checkbox"/> Yes	Heart Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes
Low Blood Pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	Stroke	<input type="checkbox"/> No <input type="checkbox"/> Yes	Pacemaker	<input type="checkbox"/> No <input type="checkbox"/> Yes
Kidney Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	Asthma	<input type="checkbox"/> No <input type="checkbox"/> Yes	Lung Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes
Thyroid Problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	Rheumatic Fever	<input type="checkbox"/> No <input type="checkbox"/> Yes	Cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes
Arthritis	<input type="checkbox"/> No <input type="checkbox"/> Yes	Aids/Hiv +	<input type="checkbox"/> No <input type="checkbox"/> Yes	Gastric Reflux	<input type="checkbox"/> No <input type="checkbox"/> Yes
Anemia	<input type="checkbox"/> No <input type="checkbox"/> Yes	Migraine Headaches	<input type="checkbox"/> No <input type="checkbox"/> Yes	Bleeding Problems	<input type="checkbox"/> No <input type="checkbox"/> Yes

PAST CARDIAC PROCEDURE	YEAR	NORMAL/ABNORMAL
24 hour Holter Monitor		
Event Monitor		
Echocardiogram		
Stress Test		
Stress Echocardiogram		
Stress Nuclear Test		
Cardiac Catheterization		
Electron Beam CT		



Internal Medicine *Continued*

(Please Fill Out Completely)

Patient's Last Name				First Name				MI
Social Security Number	Date of Birth	Age	Cell Phone			E-mail Address		
Address (Street, Route, Apt. No., etc.)					City	State	Zip Code	
Home Phone		Marital Status		Sex	Driver's License Number	Employed By		
Business Phone	Is it okay to call you at work? <input type="radio"/> YES <input type="radio"/> NO	Employer's Address			City	State	Zip Code	

Guarantor Information

Name	Address	City	State	Zip Code
Home Phone	Social Security Number	Date of Birth	Relationship to Patient	
Employed by		Business Phone		
Employer's Address		City	State	Zip Code
Emergency Contact (Friend or relative not at Patient's address who can get a message to you.)			Daytime Phone	
Referring Physician		Pharmacy	Pharmacy Phone	
How did you hear about us?				

Insurance Information

Primary Health Insurance Company _____
 Ins ID# _____ Policy # _____
 Insured Name _____ Date of Birth _____ Sex ____ Rel _____

Secondary Health Insurance Company _____
 Ins# ID _____ Policy # _____
 Insured Name _____ Date of Birth _____ Sex ____ Rel _____

List Any Persons to Whom You Will Allow Access Of Your Medical Records

Name _____ Relationship to Patient _____
 Name _____ Relationship to Patient _____

***The doctor's service is provided directly to you and not to an insurance company. Therefore, we cannot render services on the assumption that our charges will be paid by an insurance company. All services are charged directly to the patient, and he or she remains personally responsible for payment. As a courtesy, we will file any and all claims as authorized by you and will assist in making collections from the insurance company and then will credit all such collections to your account. By signing below, I hereby authorize SJMG, LLC to furnish information concerning my present medical care to the insurance company that is listed above.*

*I direct the insurer to Pj without equivocation, directly to SJMG, LLC, all benefits due them as a result of the claim. Although covered by insurance, I am aware that I am personally responsible for all charges. A photostatic copy of this authorization will be as valid as the original.***

Signature of Patient _____ Date _____
I acknowledge that I have been given access to the 'Notice of Privacy Practices' for SJMG, LLC, .

Signature of Patient _____ Date _____



Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for the office of Saint Joseph's Medical Group to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). [The office's Notice of Privacy Practices provides 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. The office of Saint Joseph's Medical Group reserves the right to revise its Notice of Privacy Practices anytime. A revised Notice of Privacy Practices maybe obtained by forwarding a written request to the Practice Administrator.

With this consent, the office of Saint Joseph's Medical Group may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that may assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, the office of Saint Joseph's Medical Group may mail to my home or their alternative 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 – (We do not mark ours personal and confidential)

With this consent, the office of Saint Joseph's Medical Group may e-mail to my home or other alternative location any times that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that the office of Saint Joseph's Medical Group restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the office of Saint Joseph's Medical Group 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, or later revoke it, the office of Saint Joseph's Medical Group may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Patient's Name

Print Name of Patient or Legal Guardian

Date



FINANCIAL PAYMENT POLICY

We find that communication with our patients regarding our financial policy assists us in providing the best service to you. We have therefore taken the time to answer some of the most commonly asked questions.

How may I pay?

We accept payment by cash, check, VISA, MasterCard, Discover, and American Express.

What is my financial responsibility for services?

Your financial responsibility depends on a variety of factors, explained below.

<i>If you have.....</i>	<i>You are responsible for.....</i>	<i>Our staff will.....</i>
Commercial Insurance Medicare Medicare Replacement	Payment of the patient responsibility for all office visits, injections, office procedures and other charges at the time of office visit.	File an insurance claim as a courtesy to you.
HMO & PPO plans with which we have a contract	<u>If the services you receive are covered by the plan:</u> All applicable copays and deductibles are requested at the time of visit. <u>If the services you receive are not covered by the plan:</u> Payment in full is requested at the time of visit.	File an insurance claim on your behalf.
HMO with which we are not contracted and are not applying for.	Payment in full for office visits, injections, office procedures and other charges at the time of visit.	Provide the necessary information for you to complete and file your claim directly with the insurance company.
Point of Service Plan or Out of Network PPO	Payment of the patient responsibility – deductible, copay, non-covered services-at the time of the visit.	File an insurance claim on your behalf.
No Insurance	Payment in full required at the time of service.	

We feel strongly that it is the patient's responsibility to be aware of the requirements and limitations of their own benefits and insurance plans. Please let our office know if your insurance has requirements regarding participating outpatient facility and laboratory. For services rendered in our office and out patient facilities please note that you may also receive bills from other non-Saint Joseph's entities for services rendered in conjunction with your care (i.e, laboratory services).

Any patient who is seen and fails to notify our office of any changes in their insurance that in turn deems their services as non-covered will be billed directly for these charges. In exchange for filing your insurance, you agree to provide current insurance information and picture I.D at every office visit. We understand that filling out forms is at times tedious; we do our best to simplify this process.

Co-pays are required at the time of the visit.

Check Policy

We are happy to accept your personal check for payment toward your account balance. However, if funds are not available in your account and your check is returned to us as a NSF (or for any other reason), you will be assessed a \$35 service fee plus the amount of the original check. You may be required to make future payments using cash, credit card or money order.

No Show Policy/ Late Cancellation Policy

Any time that you miss an appointment in our office or cancel an appointment without giving us 24 hours notice, you will be assessed a \$35-\$250 for no-show/late cancellation fee. The fees for the most common appointments are listed below:

Appointment Type	Fees
Office Visit	\$35-\$50
Physical Exam	\$50
Surgery- Office Procedure	\$125
Surgery- Hospital procedure & Nuclear Testing	\$250

This fee will be your responsibility and must be paid in full prior to your next visit. Dismissal from our practice may result following 3 No Shows.

Application/ Form Completion Fees

A prepayment fee up to \$35 must be paid in full for forms and applications completion such as school physical, sport physical, disability application, and others that do not require you to come to the office.

Medical Record Fees

Charges for Medical Records copies will be determined in accordance with the current State of Georgia Office of Planning and Budget published rates. Minimum costs are approximately \$25.00 as a base fee in addition to a **per page cost of \$1.00.**

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments, deductibles, and co-insurance amounts, are my responsibility.

Date

Signature

Printed Name