

Johnson & Murthy Family Practice
Drs. Johnson, Murthy & Hasan
 1500 Oglethorpe Avenue
 Suite 200C
 Athens, GA 30606
 Phone: (706) 548-5833 Fax: (706) 548-5608

Please Fill Out Completely:

New patient paperwork for minor

Patient's Last Name					First Name					MI
Social Security Number	Date of Birth	Age	Gender	Race	Ethnicity (Circle one): Latino Non-Latino Other			Language		
Address (Street, Route, Apt. No., etc.)					City			State	Zip Code	
Home Phone		Cell Number			Cell phone carrier (ex. Verizon)					
Email Address					Best way to contact (Circle one): Home Phone Cell Phone Email Letter					

GUARDIAN INFORMATION

Name		Address			City		State	Zip Code	
Home Phone	Social Security			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		

St. Mary's Medical Group will use the email provided above to enroll you into our patient portal. You will receive an email to complete the enrollment process.

Is the email given above used by another member of your household or family? If yes, by whom: _____

Are you a currently patient at any other St. Mary's Medical Group Location? If so, which locations: _____

INSURANCE INFORMATION (Please provide your insurance card(s) at the time of visit)

If your insurance policy holder is different from the guardian information provided above please complete this section.

Name		Address			City		State	Zip Code	
Home Phone	Social Security			Date of Birth		Relationship to Patient			

Patient or Guardian Signature

Date

JOHNSON & MURTHY FAMILY PRACTICE
OWNED AND OPERATED BY ST. MARY'S MEDICAL GROUP, INC.
A SUBSIDIARY OF ST. MARY'S HEALTH CARE SYSTEM, INC.
("SMMG")

CONSENT TO TREATMENT

I hereby authorize and consent to such care, examinations and treatments including, but not limited to, any medical care or treatment, examinations, diagnostic procedures, and the furnishing of such supplies in connection with or relating to treatment as are necessary or desirable in the judgment of the treating physician.

FINANCIAL AGREEMENT

I hereby assume full responsibility for all charges incurred for professional services rendered by SMMG physicians. I agree that in return for the services provided to me, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to the above mentioned medical practice for payment. If any account is sent to collections, I agree to pay collection expenses.

ASSIGNMENT OF PAYMENT OF BENEFITS

In consideration of SMMG advancing or extending credit to me for my care, I hereby assign and transfer to SMMG all benefits and payments now due and payable or to become due and payable to me under any insurance policy or policies, under any replacement policies thereof, under any self-insurance program, or under any other benefit plan. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

I request payment of authorized Medicare benefits for me, or on my behalf, for any services furnished to me by or in SMMG, including physician services.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, the undersigned, hereby authorize SMMG or their representatives to release any of my medical information, protected health information or related information pertaining to this period of treatment, including AIDS Confidential Information and psychiatric information, that may be requested by any physician, provider, hospital, healthcare facility, any insurer or third party payor with whom I have coverage, my employer, or any public agency which may be assisting in payment of my care. I authorize SMMG to release to the Social Security Administration, Department of Medical Assistance, their intermediaries or carriers, or to review organizations, any information about me as needed for this or a related Medicare, Medicaid, or Tricare claim, including medical information relating to my treatment. I understand that health care services may be subject to review by review organizations as well

I HAVE READ THE FOREGOING CONSENT TO TREATMENT, FINANCIAL AGREEMENT, ASSIGNMENT OF PAYMENT OF BENEFITS, AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION. I AM AWARE OF THE CONTENTS OF EACH AND FULLY UNDERSTAND EACH.

I ACKNOWLEDGE THAT I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES OF ST. MARY'S HEALTH CARE SYSTEM, INC.

IN WITNESS WHEREOF, I HAVE PLACED MY HAND AND AFFIXED MY SEAL AS OF THE DATE INDICATED BELOW.

Patient Name (Print)

Patient Date of Birth

Patient or Guardian Signature

Date

I have agreed to let certain individuals participate in discussions and decisions related to my health care. I thereby give permission for Johnson & Murthy Family Practice owned and operated by St. Mary's Medical Group, Inc. a subsidiary of ST. MARY'S HEALTH CARE SYSTEM and Doctor _____ to discuss my personal health care information with the following individual(s).

Name/Relationship _____ Phone Number _____

Name/Relationship _____ Phone Number _____

Name/Relationship _____ Phone Number _____

Conditions for Disclosure (check all that apply):

- The Clinic may disclose my personal health information to the individual(s) above **only** in my presence.
- Unless indicated otherwise, the Clinic may disclose my personal health information to the individual(s) above in my presence and when I am not physically present, including disclosures by telephone, facsimile, e-mail or regular mail.
- Other conditions of disclosure: _____

I understand that this consent may be revoked by me at any time by written notice to our office.

Patient signature: _____ Date: _____

Legal Representative: _____ Date: _____

Reason for Representative: _____

FCA: 06/03

Some or all of the health care professionals performing services in this Health Care System are independent contractors and are not Health Care System agents or employees. Independent contractors are responsible for their own actions and the Health Care System shall not be liable for the acts or omissions of any such independent contractors. O.C.G.A. 51-1-29.5(d)

Consent For Disclosure to Family Member and/or Personal Representative for Johnson & Murthy Family Practice and St. Mary's Health Care System, Inc.

Patient Name _____
Address: _____ _____
Date of Birth: _____
SSN# _____
Telephone # _____

Authorization for Release of Medical Information

Patient: _____ **Date of Birth:** _____
(First) (Last)

I authorize the use or disclosure of the above-named patient's protected health information as described below.

I hereby authorize _____ to release the information.

For the purpose of: _____

Check Type of Record to be Released

Complete Health Record (or check for certain sections)

- | | | |
|--|---|--|
| <input type="checkbox"/> ER Record | <input type="checkbox"/> Office Notes | <input type="checkbox"/> Echocardiogram Results |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Most Recent Lab Work
(BMP, CMP, Lipids, LFTs) | <input type="checkbox"/> Nuclear Stress Test Results |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> EKG | <input type="checkbox"/> CT Scan Results |
| <input type="checkbox"/> Consultation Report | <input type="checkbox"/> Chest X-Ray Report | <input type="checkbox"/> Carotid-Vascular Study
Results |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Exercise Stress Test Results _____ | <input type="checkbox"/> Other as
Specified _____ |
| <input type="checkbox"/> Nursing Documentation | | |

I understand that information in my health record may include information relating to Confidential Information and may include mental health, HIV/AIDS diagnosis, alcohol and drug use information and I also authorize the release of this information.

I understand this authorization may be revoked by me at any time. This must be in writing to the Office Manager. This would not apply to information that has already been released prior to my written revocation.

I understand that information disclosed under this authorization may be subject to re-disclosure by the recipient of such information and the information may no longer be protected under the terms of this authorization or by federal privacy laws.

I understand I may refuse to sign the authorization.

Patient Signature **Date:** ____/____/____

Printed Name of Legal Representative **Date:** ____/____/____

If signed by Legal Representative please provide the following:

Relationship to patient: _____

Authority to sign on Behalf of the Patient: Custodial Parent Durable Power of Attorney for Healthcare
 Other, Please describe: _____

Records may be faxed and/or mailed to the fax number and the address provided above.

Johnson & Murthy Family Practice

Annual/New Medical History Intake Sheet

Patient Name: _____ Birth Date: ____/____/____ Date: _____

Describe your main problem today: _____ Allergies: _____

Where is your problem located? _____

How severe is your problem? _____

How long have you had this problem? _____

When does this problem occur? _____

What other things happen with this problem? _____

List previous hospitalizations/surgeries/serious injuries and when?

Date of last immunizations: Tdap _____ Hep B _____ Hep A _____

Chicken Pox _____ Meningitis _____ Pneumococcal _____

Flu _____

Monthly self breast exam? No Yes
 Form of regular exercise? No Yes _____
 Seat belt use? No Yes

Social History:

Marital Status: Single Married Separated Divorced Widow(ed)

Use of Alcohol: Never Rarely Moderate Daily _____
 Will discuss in person/confidential disclosure

Use of Tobacco: Never Previous but quit Current packs per day _____
 Will discuss in person/confidential disclosure Passive exposure

Use of Drugs: Never Type/frequency _____
 Will discuss in person/confidential disclosure

Excessive exposure at home or work to: Fumes Dust Solvents Noise

Other exposure _____ School: _____ Grade: _____

Family Medical History:

	Age	Disease	If Deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____

Who lives in the home: Mom Dad Grandmother Grandfather Stepmother Stepfather
 Siblings Other

If other, please explain: _____

Have you ever had the following?

Thyroid disease yes no
 Diabetes yes no
 Hypertension yes no
 Cancer yes no
 Stroke yes no
 Heart trouble yes no
 Arthritis or gout yes no
 Convulsions yes no
 Bleeding Tendency yes no
 Acute infections yes no
 Sexually transmitted disease ... yes no
 Hereditary defects yes no

List medications you are currently taking including nonprescription or herbals

1) _____
 2) _____
 3) _____
 4) _____
 5) _____
 6) _____
 7) _____
 8) _____
 9) _____
 10) _____

Johnson & Murthy Family Practice

Patient

Name: _____

Date: _____

GENERAL

Fever NO YES
 Chills NO YES
 Change in Appetite NO YES
 Fatigue NO YES
 Weight loss NO YES
 Weight gain NO YES

EYES

double vision NO YES
 blurred vision NO YES
 change in vision NO YES

ENT

Ear Pain NO YES
 Decreased hearing NO YES
 Difficulty swallowing NO YES
 Sore throat NO YES
 Voice Change NO YES
 Sinus problems NO YES

CARDIOVASCULAR

Chest pain or Discomfort NO YES
 Racing/skipping heart beats NO YES
 Shortness of breath with exertion NO YES
 Swelling -feet,ankles, hands NO YES
 Leg pain with exertion NO YES
 Varicose Veins NO YES

RESPIRATORY

Sleep disturbance due to breathing NO YES
 Cough NO YES
 Shortness of breath NO YES
 Wheezing NO YES

FEMALE

Breast Pain NO YES
 Breast Lump NO YES
 Breast discharge NO YES
 Pain with periods NO YES
 Irregular periods NO YES
 Vaginal discharge NO YES

GASTROINTESTINAL

Indigestion/heartburn NO YES
 Nausea NO YES
 Vomiting NO YES
 Abdominal Pain NO YES
 Diarrhea NO YES
 Change in bowel habits NO YES
 Dark tarry stools NO YES
 Bloody stools NO YES

GENITOURINARY

Dysuria NO YES
 Hematuria NO YES
 Urinary Frequency NO YES
 Urinary Hesitancy NO YES
 Nocturia NO YES
 Incontinence NO YES
 Decreased Libido NO YES
 Erectile dysfunction NO YES
 Testicular pain NO YES

MUSCULOSKELETAL

Joint Pain NO YES
 Joint Swelling NO YES
 Muscle Aches NO YES

DERMATOLOGIC

Suspicious lesions NO YES
 Itching NO YES
 Rash NO YES
 Dry skin NO YES

NEUROLOGICAL

Difficulty with concentration NO YES
 Headaches NO YES
 Falling Down NO YES
 Weakness NO YES
 Tremors NO YES
 Memory Loss NO YES
 Numbness/tingling NO YES
 Lightheadedness NO YES
 Vertigo NO YES

PSYCHIATRIC

Anxiety NO YES
 Depression NO YES
 Sleep Problems NO YES

ENDOCRINE

Cold Intolerance NO YES
 Heat Intolerance NO YES
 Excessive Urination NO YES
 Excessive thirst NO YES

HEMETOLOGICAL

Enlarged Lymph Nodes NO YES
 Bleeding NO YES
 Abnormal bruising NO YES
 Anemia NO YES

ALLERGY

Food Allergies NO YES
 Year-Round Allergies NO YES
 Hives or Rash NO YES
 Seasonal Allergies NO YES

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eRx Consent

ePrescribing is a federally mandated initiative that requires all physicians to prescribe medications electronically beginning in 2011.

ePrescribing software sends your prescriptions over the internet to your pharmacy in a safe, secure way through the same technology used by credit card companies. This helps protect the privacy of your personal information.

ePrescribing software also lets your physician see important information like drug interactions and your prescription history.

The benefit to you is:

- Less confusion over handwritten prescriptions or unclear phone calls.
- Reduced possibility of medical errors.
- Less chance of adverse drug reactions.
- Fewer trips to drop off at the pharmacy.
- A safer, faster, easier way to get your prescription filled.

Patient Consent:

I agree that Johnson & Murthy Family Practice may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

Patient Signature (or legal guardian)

Print Patients Name

Primary Pharmacy Name

Pharmacy Street and City

Date

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Dear Patient:

It has come to our attention that there is confusion concerning annual preventive care visits and/or annual wellness visits that occur on the same day as a follow-up office visit. Follow-up visits can be for your chronic medical problems and/or new problems or concerns that have arisen since your last appointment here in our office.

- Your annual wellness visit, and/or preventive care visit includes: a review of your overall health and recommended screening procedures (such as mammograms, colonoscopies and certain lab tests) and preventive measures (such as vaccinations) that may be beneficial in maintaining overall good health.
- The office visit includes: review of new and/or acute problems or concerns and chronic medical conditions such as hypertension and diabetes.

If you have a new medical problem that needs evaluation and requires your physician to order specific tests and/or medications, this must be billed as a separate office visit. If you have chronic medical conditions that require supervision and surveillance and ordering of specific tests and medications, this is not included in the wellness visit and must be billed as a separate office visit. **As a benefit to you, we offer you the option to have both of these visits done on the same day.** This will prevent you from having to schedule separate exams on separate days.

You can choose to do them on separate visits if you prefer. If you have a health concern, please inform your physician. They will let you know if it will be better to be addressed on the same day as the preventive visit.

If you have any questions concerning this, please ask to speak to the billing staff or the office manager.

I acknowledge receipt of and understanding of this policy.

Patient Name

Patient Date of Birth

Patient or Guardian Signature

Date