Candler Internal Medicine

106 Briarwood Rd
Statesboro Ga 30458
Phone: 912-871-5000
Fax: 912-681-1444

380 Sconyers Street
Metter, Ga. 30439
Phone: 912-685-3992
Fax: 912-681-1444

Rani Reddy, MD Qian Tang, FNP Erica McDaniel, NP

Personal Information

Name:_____ Date of Birth: _____ Social Security Number: _____

Race:_____ Gender: M F Marital Status: M S D W

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

Home Phone: _____ Cell Phone: _____ Email: _____

Spouse Name: _____ Date of Birth: _____ Spouse Phone:_____

Emergency Contact:_____ Phone: _____

Employer: _____ Work Phone: _____

Do you have an Advanced Directive? Yes No

Insurance Information

Primary Insurance: _____ Member Name: _____

Secondary Insurance: _____ Member Name: _____

Payment and Assignment of Insurance Benefits

By signing below you acknowledge that you have read and understood all below agreements.

1. I agree to pay, at the time of service, any required co-payments, co-insurance, and deductibles, as well as charges for services not covered by my insurance.
2. I understand that I am financially responsible for any balance not covered by my insurance and that all unpaid balances will be billed to my address on file with this office and that I am responsible for updating my registration information as necessary.
3. I understand that past due accounts will be referred to a collection agency and that I will be responsible for all collection charges, associated legal fees, and the full balance on my account.
4. I understand that there is a $35 charge for returned checks.
5. I hereby authorize and direct payment of medical benefits to Candler Internal Medicine for Services rendered by Physician or Nurse Practitioner.
6. I hereby authorize Candler Internal Medicine to release my protected health information (PHI), any medical or incidental information that may be necessary for medical care, in processing applications for financial benefits, my insurance companies or other third party payers, including their representatives as necessary.
7. I understand that there will be a $50 No Show fee for appointments that are not cancelled 24 hours in advance.

You are entitled to make informed decisions regarding your medical care. To assist you in making an informed decision, you are hereby notified that your physician has ownership interest in East Georgia Regional Medical Center.

Patient Signature: _____ Date:_____

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Candler Internal Medicine Patient HIPAA Consent Form

Patient's Name: _____ Date of Birth: _____

I understand that the patient's health information is private and confidential. I understand that Candler Internal Medicine works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Candler Internal Medicine may use and disclose the patient's personal health information to help provide healthcare to the patient, to handle billing and payment, and to take care of other health care operations.

I understand that Candler Internal Medicine utilizes an electronic medical record system. I understand that this system is maintained in accordance with HIPAA and other patient privacy and health information management regulations.

Patient Signature: _____ Date:_____

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Authorization to Release Confidential Medical Records

I, _____ hereby request and authorize _____ to disclose and provide copies of any and all treatment records and information concerning my care which is in the possession of this person or entity to

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I understand that these records include, but are not limited to: personal patient information, medical and dental histories, examination records, radiographs, clinical photographs, treatment plans, treatment records, referral and consultation recommendations and reports, diagnostic models, any history of Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS), sexually transmitted infections, behavioral health/psychiatric care, treatment for alcohol and/or drug abuse, or similar conditions.

I understand that there may be information in these records that I would not want released. I have been provided a copy of Candler Internal Medicine's Notice of Privacy Practices and any charges that may be associated with this authorization. I have discussed any concerns I may have about the use, release, and disclosure of my health information with Candler Internal Medicine assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release Candler Internal Medicine from all legal liability that may arise from this authorization.

Patient or Guardian Signature: _____ Date: _____

If Guardian, reason: _____

Patient Name: _____ DOB: ___/___/_____

Relation to Patient: _____

The patient or their representative may revoke this authorization by notifying in writing Candler Internal Medicine. Federal Law states that the treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the Privacy Rule. Federal Law also requires a statement that there is the potential for the protected health information released under this authorization may be subject to disclosure by the recipient.

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Authorization to Disclose Health Information

Patient Name: _____ Date of Birth: ___/___/_____

Best Contact Number: ____-____-_____ Approved to leave a detailed message YES NO

Secondary Number: ____-____-_____ Approved to leave a detailed message YES NO

Many of our patients allow family members such as their spouse, parents, or others to call and request medical or billing information. Under the requirement of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members, you must sign this form giving us permission to release your information. Information will only be released to individuals listed on this form.

I authorized Candler Internal Medicine to release my medical and/or billing information to the following individual(s)

1. _____ Relation to patient _____ Contact # ____-____-_____
2. _____ Relation to patient _____ Contact # ____-____-_____
3. _____ Relation to patient _____ Contact # ____-____-_____
4. _____ Relation to patient _____ Contact # ____-____-_____

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand that information disclosed to any of the above recipients is no longer protected by federal or state law and may be subject to disclosure by the above recipient. The direction to revoke this authorization must be produced in writing in addition to any verbal direction. Any limits which I desire to place on this authorization must also be provided in writing.

Patient Signature: _____ Date: ___/___/_____

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Practice Policy on Patient Compliance

Candler Internal Medicine imposes the following policies with regard to patient compliance with medical direction:

- Patients who no-call-no-show for their New Patient appointment will be rescheduled only once.
- Patients with three consecutive no-call-no-show appointments are eligible for dismissal from the practice at the discretion of their provider.
- We require 24 hours notice if you are unable to keep an appointment. If we are not informed in a timely manner, your missed appointment will be counted as a no-call-no-show.
- All medication refill requests should be called to your pharmacy. There is a **minimum 48 hour** turnaround time on prescription refill requests.
- Medications for chronic diseases will be written with ample refills for 30 or 90 days at time of service. When you are down to a 30 day supply you need to call and be sure that you have an appointment within the next 20 days for a medication review and to be sure to avoid a lapse in medication coverage.
- **IF you are prescribed a CONTROLLED substance, you MUST have an appointment every FOUR weeks to maintain compliance. Medications will NOT be refilled before the 30 days. NO EXCEPTIONS.**
- For the safety and well being of our patients, no new medications will be called in over the phone after hours by the on-call physician.
- We understand that unexpected situations arise and therefore at the discretion of your provider an additional supply of **not more than 30 days** may be called in to prevent a prolonged absence of medication while waiting for a routine appointment which will involve a review of medications.

By Signing below, I certify that I have read this agreement fully and that I understand the policies listed above completely.

Printed Name: _____ Date of Birth: ___/___/_____

Patient/Guardian Signature: _____ Date: ___/___/_____

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Candler Internal Medicine New Patient Medical History

Patient's Name: _____ Date of Birth: _____

Preferred Pharmacy: _____

Reason For Visit: _____

Past Surgical History (Include year and hospital)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Past Hospitalizations (Include reason, year, and hospital)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Any history of transfusions? _____

Social History:

Family History

Mother Alive?_____ Age:____
Any major Illnesses:
_____
_____

Father Alive?_____ Age:____
Any major Illnesses:
_____
_____

Siblings: _____ Brothers: ____ Sisters:_____
Any major Illnesses:
_____
_____

Children: _____ Sons: _____ Daughters: ____
Any major Illnesses:
_____
_____

Alcohol Use

__ Never __ Occasional __Daily (1-3) __Heavy (more than 3 per day) __Quit Drinking Alcohol

Tobacco Use

__ Never __ Occasional __Daily __Heavy (pack a day) __Quit Smoking __Other Tobacco

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Other Drug Use

Have you ever used recreational or illicit drugs?_____ If yes, Describe: _____

Have you ever felt like you use too much alcohol or drugs? _____

Medication List: Include medication, dose, and prescribing physician.

_____

_____

Medical History (Mark next to each applicable diagnosis)

Eyes, Nose, Throat:
- ○ Deaf
- ○ Blind
- ○ Cataract
- ○ Glaucoma
- ○ Other Hearing Problems
- ○ Other Vision Problems

Heart:
- ○ Heart attack
- ○ Angina
- ○ Congestive Heart Failure
- ○ High Blood Pressure
- ○ Pacemaker
- ○ Cardiac Cath
- ○ Other Heart Problems

Lungs:
- ○ Asthma
- ○ Lung Disease
- ○ Emphysema
- ○ COPD
- ○ Chronic Bronchitis
- ○ Lung Cancer
- ○ Pneumonia
- ○ Tuberculosis
- ○ Other Lung Problems

Stomach and Bowel:
- ○ Stomach Ulcer
- ○ Irritable Bowel Syndrome
- ○ Colon Cancer
- ○ Hepatitis
- ○ Liver Disease
- ○ Other Stomach and Bowel Problems

Kidney:
- ○ Kidney Disease
- ○ Dialysis
- ○ Kidney Stones
- ○ Other

Muscle and Bone:
- ○ Skin Disorder
- ○ Broken Bone
- ○ Rheumatoid Arthritis
- ○ Osteoarthritis
- ○ Osteoporosis
- ○ Join Disease
- ○ Gout
- ○ Other Bone/Muscle Problems

Nervous System:
- ○ Stroke
- ○ Brain Injury
- ○ Nerve Injury
- ○ Memory Problems
- ○ Other Nerve Problems

Endocrine:
- ○ Thyroid
- ○ Diabetes
- ○ Adrenal Disorders
- ○ Other Endocrine Problems

Male:
- ○ Erectile Dysfunction
- ○ Low Testosterone
- ○ Prostate Problems

Female:
- ○ PolyCystic Ovarian Syndrome
- ○ Irregular Menstruation
- ○ Menopause
- ○ Painful Intercourse

Other/Multisystem:
- ○ Psychiatric/Mental Health
- ○ HIV/Aids
- ○ Anemia
- ○ Hyperlipidemia
- ○ Other problems of Blood Chemistry
- ○ Other Multisystem problems
- ○ Attention Disorders

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Additional Medications

Medication, Dose, Directions	Prescribing Physician, Specialty

Explanation of “Other” Medical History Disorders
