Social History

Have you used drugs other than those for medical reasons in the past 12 months? O Yes O No

Did you have a drink containing alcohol in the past year? O Yes O No

If yes, how many alcoholic drinks do you have per week? O 1-2 O 3-5 O 5-8 O 8-10 O 10+

Are you a O Current Smoker O Former Smoker

If a current smoker, how many cigarettes do you smoke per day? O 1-10 O 10-20 O 20+

If a former smoker, how long has it been since you last smoked?

O Less than 1 month O 1-6months O 6-12 months O 1-5 years O 5+ years

Family History

Is your father living or deceased? O Living O Deceased

Father's medical conditions: _____

Is your mother living or deceased? O Living O Deceased

Mother's Medical Conditions: _____

Do your siblings have any medical conditions? O Yes O No

Sibling's Medical Conditions: _____

Past Medical History

Please select any of the following conditions that apply to you:

- O Hypertension
- O Diabetes
- O Asthma
- O Heart Disease
- O Arthritis
- O Back Pain
- O Acid Reflux
- O AIDS/HIV
- O Anxiety
- O Atrial Fibrillation
- O ADD
- O Benign Prostatic Hypertrophy
- O Carotid Artery Stenosis
- O Constipation
- O Cough (chronic)
- O Coronary Artery Disease
- O Depression
- O Fatty Liver
- O Fibromyalgia
- O Gastrointestinal Bleed
- O Heart Murmur
- O Bleeding Disorder
- O Liver Problems
- O Hepatitis
- O Varicose Veins
- O Uterine Fibroids
- O Typhoid Fever
- O Other _____

Have you ever been hospitalized? O Yes O No

If yes, please list the year and reason: _____

Have you ever had any surgeries? O Yes O No

If yes, please list the year and surgery: _____

Current Medication

Do you currently take any medications or supplements? O Yes O No

If yes, please list each medication, the dosage, and how frequently you take it:

Medicine	Dosage	Frequency (1x daily, as needed, etc.)

Preferred Pharmacy

Please select your pharmacy and provide either the address or phone number:

CVS Walgreens Publix Kroger Walmart Other: _____

Address: _____

City, State, Zip Code: _____ Phone Number:_____

Crabapple Medical Center PC

282 Rucker Rd, Ste. 140, Alpharetta, GA 30004

Phone: 770-360-9484

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

Crabapple Medical Center PC

282 Rucker Rd, Ste. 140, Alpharetta, GA 30004

Phone: 770-360-9484

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we call, email, or send a text to confirm appointments?

YES NO

May we leave a message on your answering machine at home or on your cell phone?

YES NO

May we discuss your medical condition with any member of your family?

YES NO

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If YES, please name the members allowed:

_____

_____

This consent was signed by:

_____

(PRINTED NAME)

_____ _____

(SIGNATURE) (DATE)

_____ _____

(WITNESS SIGNATURE) (DATE)

Crabapple Medical Center PC

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Phone: 770-360-9484

Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your

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insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.
8. **Missed appointments.** Our policy is to charge $25 for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date

MEDICATION / PRESCRIPTION REFILL POLICY

- Always bring in all your medications or a current updated medication list to your office visit.

- We do not prescribe or refill chronic opioid / pain management medication. For acute pain, short term narcotics / opioid medication may be prescribed for no more than a one-week supply.

- Narcotics and other controlled substance refills, including ADHD medication, sleep aids etc., will require a mandatory visit every three months. These patients may be subject to a random urine drug screen as well.

- Antibiotics will not be called in and an office visit is required for proper evaluation and prescription of antibiotics.

- Once a refill request is received we will try to refill the medication as soon as possible, but please allow 2 business days (not including weekends or holidays) for processing.

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____	_____
Signature of Patient or Personal Representative	**Date**
_____	_____
Printed Name of Patient or Personal Representative	**Relationship to Patient**
_____	_____
Printed Name of Witness	**Employee Job Title**
_____	_____
Signature of Witness	**Date**