Rutland Family Healthcare
WELCOME TO OUR PRACTICE

Thank you for choosing Rutland Family Healthcare for your health needs. We are looking forward to meeting you! Included in this package, there is some important information to help your first visit be the best experience possible. Please fill out all information completely and bring it with you to your appointment. Along with all your insurance cards, & picture I.D. We go by appointments only! We do not do walk-in appointments.

MEDICATIONS: Please bring with you ALL medications you are currently taking or have been advised to take. This includes any over the counter medications as well as herbal or natural supplements.

MEDICAL RECORDS: It would be helpful to have access to your prior medical records so that your health history is available to us to reference. We have included a medical release form for you to complete and send to your physician to have your medical records sent to our office before your appointment or you need to pick them up and bring with you.

PAYMENT: Payments and/or Co-pays are due at the time the services are rendered. We do participate with most insurance companies; however, it is up to you to verify your insurance to make sure we are on your plan. We accept major credit cards, personal checks, or cash. Please arrive 15 minutes prior to your scheduled appointment to allow for any additional paperwork that we may need. PLEASE GIVE 24 HOUR NOTICE IF YOU CAN NOT MAKE YOUR APPOINTMENT TO AVOID A NO-SHOW FEE OF $35.00.

APPOINTMENT INFORMATION:

*DATE:*_____ *TIME:*_____

*YOUR APPOINTMENT IS WITH:*_____

5569 Houston Road
Macon, Ga. 31216

rutland
FAMILY HEALTHCARE

DEMOGRAPHICS CONSENT FORM

PRIVACY NOTICE FORM

INITIALS DATE

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about your health care. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy simply by asking or requesting one in writing.

By signing below, you acknowledge that you have been informed that there is a privacy notice in our office and that you may acquire a written copy upon request.

NURSE PRACTITIONER/PHYSICIAN ASSISTANT NOTICE

INITIALS DATE

As you are aware, our practice utilizes the expertise of physicians, nurse practitioners, and physician assistants. Each of our providers have been approved by and certified by the Georgia State Board of Medical Examiners, and are board certified.

Your signature conveys that you are in agreement with being treated by our nurse practitioners and/or physician assistants, who work alongside and under the guidance of our physicians.

REIMBURSEMENT FOR SERVICES RENDERED

INITIALS DATE

Our office accepts numerous insurance plans. We also offer discounted rates for patients without current insurance coverage. To qualify for the discounted rate, payment must be rendered in full at the time of service. If there is a copay associated with your plan, it will also be required at the time of service. Once insurance is filed, if there is any additional patient responsibility, you will receive a bill for same. It is our policy that after six monthly statements without payment or a payment plan being approved by our billing department, your account will be turned over to a collection agency. If your account is not in good standing and turned over to a collection agency, we will no longer be able to continue to provide our services to you.

CANCELLATION POLICY

INITIALS DATE

As you are aware, we are a very busy practice. We will attempt to remind you of your scheduled appointments via text, phone and/or email, per your personal preference. However, we do request that if you are unable to keep your appointment that you provide us with at least 24 hours notice. If you do not notify us that you will not be attending your appointment, we do reserve the right to enforce a $35 no-show fee, which is not covered by insurance.

PATIENT SIGNATURE DATE

RUTLAND FAMILY HEALTHCARE
REGISTRATION FORM

PATIENT INFORMATION

Last Name _____ Legal First Name _____ MI _____ Preferred Name _____

S S #: _____ _____Single _____Married _____Widowed _____Divorced

Date of Birth: _____ Age: _____ M / F

Patient Employed By: _____

Address: _____

Work Address: _____

City: _____ State: _____ Zip: _____

1st Insurance: _____ 2nd: _____

Home Phone: (_____) _____

Referring Physician: _____

Work Phone: (_____) _____

Location of Referring Phy.: _____

SPOUSE INFORMATION

Name: _____

Work Phone: (_____) _____

S S #: _____

Employer: _____

Date of Birth: _____

Work Address: _____

MUST COMPLETE IF UNDER 18

Father

Name: _____

Address: _____

S S #: _____

Date of Birth: _____

Work Phone: (_____) _____

Employer: _____

Mother

Name: _____

Address: _____

S S #: _____

Date of Birth: _____

Work Phone: (_____) _____

Employer: _____

AUTHORIZATIONS

********** PLEASE PRESENT INSURANCE CARDS TO THE RECEPTIONIST **********

- I hereby authorize the request the medical treatment necessary for the care of the above named patient.
- I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable. I allow the fax transmittal of my medical records, if necessary.
- I acknowledge full financial responsibility for services rendered by RUTLAND CORNERS FAMILY HEALTHCARE. I understand payment is due at the time of service unless other definite financial arrangements have been made prior to treatment. I understand that I am responsible for any un-met deductibles and co-insurance fees.
- I understand that insurance companies have agreements with certain laboratories for lab work and that it is my responsibility to know which laboratory my insurance authorizes and to inform the staff of RUTLAND CORNERS FAMILY HEALTHCARE as to which laboratory my insurance covers.
- I further authorize and request that insurance payments be made directly to RUTLAND CORNERS FAMILY HEALTHCARE for services rendered.
- **I have read and fully understand the above consent for treatment, release of medical information, financial responsibility and insurance authorization.**

_____ _____ _____

Patient / Parent or Guardian (Please Print) Patient/Parent or Guardian Signature Date

Emergency Contact: _____

Comprehensive Medical History

This important information is confidential. No one other than your healthcare provider will have access or knowledge of this information without your express written consent. Thank you very much for taking the time to fill our this lengthy form. Completion of this history allows us to provide you the most complete medical care possible. This form will be reviewed with you during your visit.

General:

Name:	Birthdate:	SS #:

Date of your last complete physical exam?	Date of your last chest X-ray?
Date of your last cholesterol screening?	Date of your last dental exam?
Date of your last eye exam?	Date of your last sigmoidoscopy?
Women:	**Men:**
Date of last mamogram?	Date of last PSA?
Date of last pap smear?	Date of last rectal/prostate exam?

Immunizations:			
Measles - Mumps - Rubella (MMR)	Date:	Pneumonia	Date:
Tetanus and diptheria toxoids (Td)	Date:	Hepatitis B	Date:
		Influenza	Date:

Past Medical History: (check those that apply)

	AIDS or HIV +		Chicken pox		Measles		Rheumatic Fever
	Blood or Plasma Tranfusions		Epilepsy		Mumps		Scarlet Fever
	Cancer		Infectious Mononucleosis		Polio		Whooping Cough

Hospital / Surgical History:

Illness or Operation	Date	Illness or Operation	Date
1)		4)	
2)		5)	
3)		6)	

Allergies:

Please list any drug, food, contact or environmental substances to which you have had an allergic or bad reaction.

Medications:

Please list any prescription medications, over the counter medications, vitamins, herbs or nutritional supplements that you are now taking. Please include the dosage amount and the times a day you take them.

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

Social History:

Occupation:				Marital Status:			
Do you execise regularly?	YES	NO	What type?		How often?		
I have never smoked.	YES	NO	I currently smoke packs per day.		I have smoked for years.		
I formerly smoked but stopped in: (list year)			Do you wear seat belts?		YES	NO	
Do you use other forms of tobacco?	YES	NO	Do you use illicit drugs?	YES NO	Do you drink alcohol?	YES	NO
How often/how much?			How often/how much?		How often/how much?		
Do you have any risk factors for HIV infection?	YES	NO	Have you ever been exposed to anyone with tuberculosis?		YES	NO	
Have you had excessive exposure to sun because of your work or recreation?					YES	NO	
Are you currently experienceing unusual stress?	YES	NO	Explain:				
Are there any environmental risks involved in your job or home environment?	YES	NO	Explain:				

Family History:

		Relationship			Relationship			Relationship
	Anemia			Epilepsy			High cholesterol	
	Asthma			Glaucoma			Kidney disease	
	Obesity			Leukemia			Thyroid disease	
	Cancer			Depression			High blood pressure	
	Diabetes			Heart disease			Alcohol problems	
	Stroke			Lung disease			Bleeding Tendency	

Present Age or Age of Death:	Mother:	Father:
Sibling #1	Sibling #2	Sibling #3

Women Only:	Menstrual Period Onset:	Regular?	YES	NO	Date last period began:
Age at menopause:	Difficulty with periods?	YES	NO	Specify:	

Pregnancies: No. of children:	Born Alive:	Cesarean:	Premature:	Stillborn:	Miscarriages:
Describe complications:					

RFH-05-H

Please check all conditions you currently have or have had:

General Questions
- Weight loss
- Weight gain
- Change in sleep patterns
- Change in activity capacity

Neurologic and Psychiatric
- Anxiety
- Headaches
- Depression
- Meningitis
- Paralysis
- Seizure
- Stroke
- Tingling
- Tremors
- Memory Loss
- Fainting spells, dizziness
- Head injuries
- Blackouts or near blackouts
- Change in sensation anywhere on your body
- Localized weakness or numbness

Ears, Eyes, Nose & Throat
- Hay fever
- Glaucoma
- Polyps
- Allergy
- Cataracts
- Goiter
- Hoarseness
- Double vision
- Gum problems
- Eye problems
- Ear infections
- Glasses/contacts
- Hearing Loss
- Ear discharge/pain
- Frequent nosebleeds
- Ringing in your ears
- Sinus infection
- Swollen glands

Cardiovascular
- Angina
- Chest pain
- Leg cramps
- Murmurs
- Ankle swelling
- Awakening at night short of breath & getting out of bed
- Cardiac catheterization
- Cold hands or feet
- Congenital heart defects
- Dizziness when standing up quickly
- Heart attacks
- Heart failure
- High or low blood pressure
- Irregular heart rate
- Purple fingers or lips
- Leg pain that resolves with rest
- Heart palpitations
- Varicose veins

Respiratory
- Pleurisy
- Wheezing
- Asthma
- Breathlessness when lying flat
- Prolonged cough
- Coughing up blood
- Emphysema
- Shortness of breath
- Tuberculosis
- Pneumonia
- Frequent infections (bronchitis)

Skin
- Abscess
- Dandruff
- Acne
- Oily skin
- Boils
- Rashes
- Hives
- Dry skin
- Lumps
- Psoriasis
- Jaundice
- Athlete's foot
- Excessive body odor
- Excessive sweating
- Fungal infections
- Nail problems
- Moles - irregular
- Moles - change/new

Kidney's & Urinary Tract
- Blood in urine
- Brown urine
- Dribbling after urination
- Painful urination
- Excessive thirst
- Involuntary urination/ incontinence
- Urinating frequently (day)
- Urinating frequency (night)
- Urine hesitancy
- Weak flow
- Frequent bladder infections
- Kidney disease
- Kidney stone

Endocrine
- Diabetes
- Sickle cell
- Abnormal body hair
- Changes in skin texture
- Cold intolerance
- Heat intolerance
- History of "borderline" diabetes
- Increased loss of hair
- Rheumatism
- Thyroid disease

Male & Female
- Painful sexual intercourse
- Loss of sexual interest
- Unprotected sex
- Groin itching
- Sexually transmitted diseases

Males Only
- Hernia
- Sterility
- Bloody ejaculation
- Inability to complete intercourse
- Lump on testicle
- Penile discharge
- Premature ejaculation
- Problems maintaining or keeping an erection
- Prostate disease
- Sores on penis or warts
- Testicular pain
- Testicular swelling

Musculoskeletal
- Anemia
- Arthritis
- Back pain
- Bursitis
- Gout
- Joint aches
- Neck pain
- Tendinitis
- Abnormal Blood Counts
- Blood clots in legs/lungs
- Bone Marrow Biopsy
- Easy bleeding
- Easy bruising
- Joint swelling
- Morning stiffness
- Muscle aches

Gastrointestinal
- Diarrhea
- Gallstones
- Reflux
- Vomiting
- Ulcers
- Heartburn
- Hepatitis
- Indigestion
- Abdominal pain
- Anal fissures
- Black tarry stools
- Vomiting blood
- Constipation
- Nausea
- Problems swallowing
- Hiatal hernia
- Intestinal obstruction
- Liver disease
- Hemorrhoids
- Red blood after bowel movements

Females Only
- D + C
- Hot flashes
- Hernia
- Fibroids
- Abn. bleeding between cycles
- Abnormal pap smear
- Bleeding after intercourse
- Complications w/ pregnancy
- PMS
- Endometriosis
- Heavy bleeding during cycles
- Discharge from breast
- Ovarian cysts
- Pelvic Inflammatory Disease
- Postmenopausal symptoms
- Vaginal discharge
- Vaginal Dryness
- Vaginal warts

Provider Notes

Provider Signature

Date

Family History of Cancer Questionnaire

Name: _____ Physician: _____

Date of Birth: _____ Today's Date: _____

This is a screening tool for cancers that run in families. Please consider these family members when completing the form:

Mother/Father/Brother/Sister/Children = 1st Degree

Uncle/Aunt/Grandparent/Niece/Nephew = 2nd Degree Cousin/Great Grandparent = 3rd Degree

Have you or your relatives been tested for hereditary cancer (BRCA/Colaris) in the past? YES NO

Breast & Ovarian Cancer Syndrome **HBOC/BRCAnalysis**		**SELF**	**Your Relationship To Family Member**		**Age at Diagnosis**
			Mother's Side	**Father's Side**	
Example: Breast cancer before age 50 (in self, 1st, or 2nd degree relative)	(Y) N			Aunt	48
Breast cancer before age 50 (in self, 1st, or 2nd degree relative)	Y N				
Ovarian cancer at any age (in self, 1st, or 2nd degree relative)	Y N				
Breast cancer in both breasts or two primary breast cancers in same person. With 1st cancer before age 50. (in self, 1st, or 2nd degree)	Y N				
Male breast cancer at any age (1st or 2nd degree relative)	Y N				
3 or more relatives on the same side of the family with breast or pancreatic cancer at any age (in self, 1st, 2nd, or 3rd degree relative)	Y N				

LYNCH SYNDROME/COLARIS COLON & UTERINE CANCER		**SELF**	**Your Relationship To Family Member**		**Age at Diagnosis**
			Mother's Side	**Father's Side**	
Uterine (endometrial) cancer before age 50 (in self, 1st, or 2nd degree relative)	Y N				
Colorectal cancer before age 50 (in self, 1st, or 2nd degree relative)	Y N				
3 or more Colon or Uterine Cancers on the same side of family at any age (in self, 1st, 2nd, or 3rd degree relative)	Y N				

If you circled yes to one or more statements on the Family History Questionnaire, you may be appropriate for a blood test to help determine if you have an inherited risk of cancer.

*Is there any other cancer not listed above in self, 1st, or 2nd degree relative (provide site, relationship, and age):

_____

Patient's Signature: _____ Date: _____

FOR OFFICE USE ONLY

O Patient is appropriate for further risk assessment and / or genetic testing

O Information given to patient to review Follow up appointment scheduled on _____

Patient offered genetic testing: Accepted OR Declined HCP Signature: _____

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FAMILY HEALTHCARE

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

If you are 18 years of age or older, we must have your permission to discuss your treatment, medical, or financial information, etc. With anyone other than yourself. If a person's name is not listed on the consent form, we cannot discuss your information with them.

PLEASE SIGN IN ONLY ONE OF THE AREAS BELOW

I hereby give my consent for Rutland Family Healthcare, LLC, and staff to review or discuss my medical treatment, lab results, pathology reports, and/or financial information with the following persons, other than myself. I understand that I must submit a written request to amend this list.

1. _____ Relationship:_____
   (First & Last Name) (Date of Birth) (Phone No.)
2. _____ Relationship:_____
   (First & Last Name) (Date of Birth) (Phone No.)
3. _____ Relationship:_____
   (First & Last Name) (Date of Birth) (Phone No.)
4. _____ Relationship:_____
   (First & Last Name) (Date of Birth) (Phone No.)

Signature: _____ Date: _____

OR

If there is no one that you wish your information to be released to, other than yourself, please sign below:

DO NOT RELEASE ANY INFORMATION ABOUT MY MEDICAL RECORDS OR FINANCIAL INFORMATION TO ANYONE OTHER THAN MYSELF.

Signature: _____ Date: _____

Rutland Family Healthcare
5569 Houston Road
Macon, Ga. 31216
Phone: (478) 781-5065 Fax: (478) 781-0012

NEW PATIENT PRESCRIPTION AGREEMENT FORM

1. *I agree that if I have medication left over at the end of the prescribed time, I will inform Rutland Family Healthcare.*
2. *I understand if I receive any medications. I agree to adhere to the following guidelines regarding refills of such medication:*
   a. *Refills will be made only during regular office hours, Monday through Friday. As long as you have been seen within 90 days or a reasonable amount of time as deemed by physician. Refills will not be made at night, on holidays or weekends.*
   b. *Refills will not be made for lost or misplaced prescriptions. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.*
   c. *Refills will not be made on an "emergency" basis. I will call at least seventy two (72) hours ahead if I need assistance with a medication.*

3. *My pharmacy of choice is:* _____
4. *I understand that lost, stolen or destroyed prescriptions will not be replaced and may result in discontinued treatment.*
5. *I agree to obtain medications from my prescribing physician (s) Dr.* _____. *I agree to an initial evaluation and re-evaluation on a timely basis thereafter as my physician believes is needed.*
6. *I agree to see a medication use specialist if deemed necessary by my Doctor. I understand if I do not attend this appointment, my medications may be discontinued to include refills. I understand that if this specialist feels I am at risk for psychological dependence (addiction), my medications may not be refilled.*
7. *I agree to comply with routine and/or random urine, blood or breath testing at my expense ordered by the physician(s) at Rutland Family Healthcare, documenting the proper use of my medications as well as confirming compliance. I understand that the presence*

of other controlling substances may cause my treatment at Rutland Family Healthcare to be terminated immediately for non-compliance.

8. *I understand that driving a motor vehicle may not be allowed at times while taking controlled substances and that it is my responsibility to comply with the laws of this state while taking the medication prescribed. I fully understand that I am not to drive an automobile, if any of the medications prescribed by Rutland Family Healthcare impair me in any way.*
9. *I understand that if I violate any of the above conditions, my prescriptions and / or treatment at the Rutland Family Healthcare may be terminated immediately. If the violation involves obtaining controlled substances from another individual, as described in this document, or the use, misuse or abuse of a controlled substance, I will be reported to my physician, medical facilities, and other appropriate authorities including, but not limited to , the police and the Drug Enforcement Agency (DEA).*
10. *I understand, accept, and agree that there may be unknown risks associated with the long-term use of controlled substances.*

Date: _____

Patient Name (please print) _____

Patient Signature _____

Witness _____

rutland
FAMILY HEALTHCARE

January 18, 2016

MEDICATION & SUBSTANCE MONITORING

On Wednesday, January 20, 2016, the following policies will go into effect for routine screening of patients. Our office has chosen to use MedComp Sciences and/or Labtrust to provide therapeutic monitoring laboratory services. This test will provide both you and your provider with information meant to improve your health and well-being.

Patients will receive an explanation of benefits (EOB) from their insurance company regarding the charges for these tests, with the name of the laboratory as MedComp Sciences and/or Labtrust. This is not a bill. If you have any questions regarding the explanation of benefits for tests performed by MedComp Sciences, please contact them at (855) MEDCOMP.

- ANNUAL SCREENING
  New Patients
  Annual Physicals (If not screened as a new patient within the past 3 months)

- SIX MONTH SCREENING
  Patients on at least one routine Schedule III or IV medication. This includes, but is not limited to: Ambien, Xanax, Valium, Soma, Flexeril, Ativan, Tramadol

- THREE MONTH SCREENING
  Patients on at least one routine Schedule II medication. This includes, but is not limited to, Norco, Adderall, Concerta, Oxycodone

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Each provider reserves the right to monitor patients more frequently if they feel appropriate.

I have received a copy of these policies and understand same.

DATE _____ PATIENT'S NAME _____ SIGNATURE _____

I have received a copy of these policies, and **refuse** to comply with Rutland Family Healthcare's policy. I understand my refusal may result in the provider(s) no longer prescribing my medications, and/or providing my routine health care.

DATE _____ PATIENT'S NAME _____ SIGNATURE _____

Chronic Medications

Name:_____ DOB:_____

Medication	Dosage	Directions	Date Updated	Date Updated	Date Updated	Date Updated

Drug Allergies

PATIENT PORTAL AGREEMENT

RUTLAND FAMILY HEALTHCARE, LLC offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physicians. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks, we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works

A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass- phrase to log in to the portal site. Because the connection channel between your computer and the Web site uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the Web site and your computer.

Protecting Your Private Health Information and Risks

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to get access to it.

Only you can make sure these two factors are present. We need you to make sure we have your correct email address and are informed if it ever changes. You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us.

If you pick up secure messages from a web site, you need to keep unauthorized individuals from learning your password. If you think someone has learned your password, you should promptly go to the web site and change it.

Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form and the Policies and Procedures Regarding the Patient Portal that appears at log in. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein and including the policies and procedures as set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. All of my questions have been answered and I understand and concur with the information provided in the answers.

Patient Name _____ Signature_____

Email_____ DOB_____ Todays Date_____

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FAMILY HEALTHCARE

REQUEST FOR RELEASE OF MEDICAL RECORDS

TO: _____

_____

_____

_____

I hereby request that my medical records be released to:

RUTLAND FAMILY HEALTHCARE, LLC
5569 HOUSTON ROAD
MACON, GA 31216
(478)781-5065
(478)781-0012 FAX

Patient Name: _____

Address: _____

Contact No.: _____ Date of Birth: _____

_____ _____

Patient Signature Date