

**Clear Creek OB GYN**  
**355 Clear Creek Parkway, Suite 1004**  
**Lavonia, Ga. 30553**  
Phone: (706) 356-0780 Fax: (706) 356-0781

Please Fill Out Completely:

Patient's Last Name					First Name					MI
Social Security Number	Date of Birth	Age	Gender	Race	Marital Status	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					
Employed by										
Business Phone		Employer's Address			City			State	Zip Code	

**SPOUSE/GUARDIAN** (If patient is married, give spouse information. If patient is a child, give parent 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		
<b>Emergency Contact</b> (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)

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date

**Clear Creek OB GYN**  
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 Clear Creek OB GYN 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  
Clear Creek OB GYN 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<br>(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"/> Carotid-Vascular Study<br>Results |
| <input type="checkbox"/> Operative Report      | <input type="checkbox"/> Chest X-Ray Report                               | <input type="checkbox"/> Other as<br>Specified _____       |
| <input type="checkbox"/> Nursing Documentation | <input type="checkbox"/> Exercise Stress Test Results _____               |  |

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 release 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.

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**Doctor Notes**

Patient Name: \_\_\_\_\_  
 Date: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

Allergies: \_\_\_\_\_

Please Circle: Single Married Divorced Widowed

Home Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Reason For visit: \_\_\_\_\_

**Gynecologic History (Please complete each section)**

Your age at 1<sup>st</sup> Period \_\_\_\_\_ Date of Last Period \_\_\_\_\_

How long does your period last? \_\_\_\_\_ Are your Periods Normal? \_\_\_\_\_

Do you bleed or spot in between? \_\_\_\_\_ Are you Menopausal? \_\_\_\_\_

History of STD \_\_\_\_\_ Any Bleeding since Menopause? \_\_\_\_\_

Do you take Hormones? \_\_\_\_\_ Do you have hot flashes or other symptoms? \_\_\_\_\_

Monthly Self Breast Exam \_\_\_\_\_ Date of last Mammogram: \_\_\_\_\_

Last Bone Density Scan: \_\_\_\_\_ Last Colon Cancer Screening: \_\_\_\_\_

Date of last Pap Smear: \_\_\_\_\_ Was it Normal? \_\_\_\_\_

Current Contraception: \_\_\_\_\_

Does your Insurance have a preferred Lab Service? \_\_\_\_\_

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) \_\_\_\_\_

**Pregnancies including abortions & Miscarriages:**

<u>Date</u>	<u>M/F</u>	<u>Vaginal/C-Section</u>	<u>Complications</u>

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**Allergies:**

**Name of Drug / Item and any Reactions:**

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**Major Illness or Injury:**

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**Please List any Surgeries and Dates:**

Surgery	Date of Surgery

**Personal Habits / Risk Factors**

	<u>Yes</u>	<u>NO</u>	<u>Answers</u>
Do you smoke or chew tobacco?			
Have you ever smoked in the past?			
Have you taken any drugs?			
Do you have an eating problem?			
Any Diet Preferences/Restrictions			
Type			
Number of caffeine drinks per day			
Average Alcoholic drinks per week			
Highest grade level of Educations			
Do you exercise regularly?			
What type of exercise do you do?			
How often / week?			
Any pets?			
Any Hobbies?			
Your Occupation?			

**Family Medical History:**

	Age	Disease
Father		
Mother		
Brother		
Sister		

**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 Clear Creek OB GYN 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

\_\_\_\_\_  
Secondary Pharmacy if applicable

\_\_\_\_\_  
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 Medicare 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