

St. Mary's Neurological Specialists

2470 Daniells Bridge Road

Bldg. 200 Ste. 261

Athens, GA 30606

Phone: (706) 310-1859

Fax: (706) 310-9902

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 | |
| Person responsible for payment | | Relationship to pt | Address | | | | | Phone Number | | |
| Insurance Policy Holder Name | | DOB | Address | | | | | Policy holder SSN | | |

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 | |
| Emergency Contact (Friend or relative not at Patient's address who can get a message to you.) | | | | | | | | Daytime Phone | | |

PHYSICIAN INFORMATION

Primary Care Physician _____

Address _____ Phone _____

Referring Physician (If different from Primary Care Physician) _____

Address _____ 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

ST. MARY'S NEUROLOGICAL SPECIALISTS
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 St. Mary's Neurological Specialists 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
St. Mary's Neurological Specialists and
St. Mary's Health Care System, Inc.**

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

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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"/> Office Notes | <input type="checkbox"/> Most Recent Lab Work |
| <input type="checkbox"/> CT/MRI results | <input type="checkbox"/> Results of any prior EMGs |
| <input type="checkbox"/> Carotid Ultrasound results | <input type="checkbox"/> EEG reports |
| <input type="checkbox"/> Other as Specified _____ | |

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: _____

St. Mary's Neurological Specialists
St. Mary's Medical Group

What over the counter medications or remedies do you take?

List/describe any "alternative" or "complementary" therapies you are receiving:

Medication allergies: _____

Family History

| Relative: | Father | Mother | Brother(s) | Sister(s) | Children |
|----------------------------|--------|--------|------------|-----------|----------|
| Age (if living) | | | | | |
| Cause/Age at time of death | | | | | |
| Cancer | | | | | |
| Seizures | | | | | |
| Stroke | | | | | |
| Heart attack | | | | | |
| Migraines | | | | | |
| Dementia | | | | | |
| Neuropathy | | | | | |
| Muscle problems | | | | | |
| Diabetes | | | | | |
| Parkinson's disease | | | | | |
| Psychiatric illness | | | | | |
| Multiple Sclerosis | | | | | |
| High blood pressure | | | | | |

Social History

Do you smoke?

No Did you ever smoke? _____ If so, how much? _____ How long? _____
 When did you quit? _____

Yes How much per day? _____ For how many years? _____

How much caffeine do you drink/day? _____

How much alcohol do you drink per day, week or month? _____

Family: Single Married Divorced Widowed Significant other/Partner

Do you have children? _____ How many? _____ What are their ages? _____

Occupation: _____

Educational level (how far did you go in school?): _____

Do you use recreational drugs (such as marijuana, cocaine, heroin)? _____

St. Mary's Neurological Specialists

St. Mary's Medical Group

Review of Systems: Please check symptoms you have had in the **PAST 3 MONTHS** only.

Constitutional

- Weight loss Recurrent Fevers Weight gain

Ophthalmology

- Diminished vision Blurred vision Double vision
 Flashing lights in the eyes

ENT

- Loss of hearing Ringing in the ears Difficulty swallowing
 Snoring/daytime sleepiness

Cardiac/Respiratory

- Chest pain Shortness of breath Palpitations
 Leg swelling

GI

- Abdominal pain Chronic diarrhea Chronic constipation
 Loss of bowel control Nausea/vomiting Blood in stool

GU

- Loss of bladder control Sexual difficulties Blood in urine

Musculoskeletal

- Neck pain Back pain Muscle cramping/stiffness
 Joint pain Joint stiffness Joint swelling

Endocrine

- Fatigue Intolerant of cold Intolerant of heat
 Hair loss

Hematologic

- Easy bruising Excessive bleeding Frequent infections

Neurologic

- Numbness of arms/legs Weakness of arms/legs Memory loss
 Vertigo/spinning feeling Tremors/Shaking Difficulty walking
 Poor balance Passing out Severe headaches

Dermatologic

- Rash Dry or sensitive skin

Psychiatric

- Depressed mood Trouble falling asleep Trouble staying asleep
 Anxiety Frequent worried thoughts Hallucinations
 Loss of interest in work or home activities

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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 St. Mary's Neurological Specialists 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