New patient application

Thank you for your interest in becoming a patient.

We are a practice that believes in preventative care. Our providers want and expect our patients to get colonoscopies, mammograms and other standard screenings. **Countless cancers have been caught early and lives have been saved by Dr. Kent personally, because of this philosophy**. We also prescribe statins and other medications that are proven to prevent heart attack, stroke, and other life threatening conditions.

- Many medications require follow up on a regular basis- annually, six months, or even sooner depending on the medication. This is standard of care. Our patients are expected to follow-up and take prescribed medications appropriately.
- We **DO NOT** prescribe pain medications. We **will not** refill chronic pain medication or assume responsibility for pain medication you are already taking.
- **Dr. Kent expects all of her patients to rotate through her provider staff**. She hires excellent providers to help her. If you become a patient, you will see all providers in the office at some time or another. **No one can see Dr. Kent exclusively as there is not enough of her to go around.**
- We do not file Worker's Comp or Auto Accident claims. You will need to pay out of pocket and file for reimbursement personally.

By signing below, you acknowledge this philosophy and practice expectations. **If you are not willing to abide by these and follow the provider's advice; we may not be the medical practice for you.**

Upon review of your medical history, if we feel we are an appropriate fit, you will be contacted for an appointment.

Applications do not guarantee an appointment.

Name-_____ Signature_____

Address-_____ Date-_____

_____ Phone-(____)_____

Previous Physician and Phone-_____

Last Doctor Visit-_____ Last Labs-_____

Medications-_____

_____

_____

Lifetime
MEDICAL CENTER P.C.

14244 HWY 515 N
SUITE 100
ELLIJAY, GA 30536
(706) 698-5433 FAX (706) 698-5445

AUTHORIZATION FOR AND CONSENT TO RELEASE INFORMATION

Patient Name: _____ Date of Birth: _____

Phone: _____

Release information from: _____ Phone#: _____

City: _____ State: _____ Fax#: _____

Release information to: **Dr. Alana Kent** Phone#: **(706) 698-5433**

Fax#: **(706) 698-5445**

I, the undersigned patient/guardian, hereby authorize releasing records of the patient listed above, to Lifetime Medical Center, PC, Alana Kent MD.

Please release the following information-

- Progress Notes
- Labs
- X-rays
- Hospital
- Immunizations
- Other- **Past 5 years**

Lifetime Medical Center is not responsible for any fees, if any, for the release of my medical records from other providers.

I understand this authorization includes release of all medical records including HIV records, Psychiatric Mental Illness, Drug / Alcohol abuse records, Venereal Disease and any other statutory protected diseases. This authorization and consent will expire 90 days following the date signed. I understand that I may revoke this authorization and consent at any time except to the extent that action has previously taken in reliance thereof.

_____ _____

Signature of Patient / Guardian Date

_____

Relationship to Patient