1016 Keith Dr
Perry Ga 31069

PERRY FAMILY PRACTICE | PRIVIA MEDICAL GROUP

Ph: 478-988-1515
Fax: 478-988-1550

Policies and Procedures:

Thank you for choosing Perry Family Practice. We know that you have a choice in medical providers and are pleased that you have chosen to seek care with us. The staff at Perry Family Practice strive to exceed expectations in care and service and to make your experience with us as comfortable as possible. Our goal is to provide quality medical care in a timely manner. The following information outlines some of the policies and procedures established for this practice:

Office Hours: Monday through Thursday 7:30am to 5pm (closed for lunch from 12:15 to 1:15pm) and Friday from 7:30 am to 12:15 pm.

Appointments: In our effort to provide quality care we ask patients to please call to schedule appointments. We strive to schedule appointments in a timely manner and provide ample time to address your problem. As emergencies can occur in primary care, we ask that you understand if a delay occurs on the day of your appointment. We encourage you to schedule appointments for preventative health/annual physicals and follow up for chronic conditions as far in advance as possible to ensure you get the day and time that you prefer. We do require an appointment for any paperwork that needs filled out- such a sports physical, FMLA or disability forms. As well, our providers have several appointments dedicated for same day appointments. If you need a same day appointment, please call the office as soon as possible; please leave a message and wait for a call back. Walk-in appointments should be reserved for emergency appointments only and we ask that you please call in first so we can assist you as to the need for urgent care or emergency care, if necessary.

-Preventative Physical/Annual appointments- Commercial insurance generally covers this visit once yearly per your insurance company plan. This is a screening appointment to discuss your overall health, recommended screening procedures (such as a mammogram or colonoscopy) and preventative measures that are beneficial to your health. If there are other health concerns, we will gladly address these at this appointment, but if the concern results in orders for additional tests or medications we are required per insurance to attach a regular appointment to the visit, which may result in a co-payment, payment towards deductible or coinsurance payment.

-Medicare annual wellness appointments- Once a year Medicare requires the documentation of specific paperwork (AWV) to update them about your health. To limit your trips to the office, Perry Family Practice collects this information with a regular appointment. This appointment monitors any chronic illnesses and is a general health check-up to monitor recommended screening procedures. The Medicare annual wellness appointment is filed as a regular appointment and does require a co-payment, payment towards deductible or co-insurance payment if this is applicable to your insurance.

Cancellation, No-Show and Late Arrivals Policy: If you are unable to attend your scheduled appointment, please call Perry Family Practice one business day in advance of the appointment so we can open this appointment to another patient requiring care. A no-show is someone that misses an appointment without cancelling in advance. An administrative fee of $50 will be billed to your account for this missed appointment without notice- *please note this $50 fee is a patient responsibility and insurance companies do not cover this fee. If you arrive more than thirty minutes late to an appointment, we will make every attempt to see you; however, your appointment may need to be rescheduled.

Telephone Call Policy: Every phone call is important to us at Perry Family Practice, and we will attempt to answer your calls and return your messages promptly. When calling the office for any reason please pick the correct extension for your needs If you get a voicemail, please leave all important information, including the best number to reach you, and we will call back to take care of your needs as soon as possible. Also, please do not leave multiple messages or call multiple lines and leave messages as this can delay response times. Please be aware that our nurses are not always available via telephone. They do not leave scheduled patients to return messages, and these are generally answered after patient care sessions are finished.

After Hours and Weekend Contact: For non-emergencies during the hours our office is closed, a provider from Perry Family Practice can be reached by calling our main office and choosing option 8. If you have an emergency, please call 911, or go to an Urgent Care or the Emergency Room as appropriate to your needs.

Insurance Collections: We accept dozens of insurance plans requiring various deductibles and co-pays. It is important that you read and understand your policy. If necessary, please ensure that your assigned provider is listed as primary with your policy. You are responsible for paying for all services not covered by your insurance plan. Please bring your insurance card to every appointment and please update any changes to your insurance plan while checking in for appointments. All co-pays and account payments are due at time of service and will be collected at each appointment. Perry Family Practice will make all reasonable attempts to collect outstanding balances should they occur. If reasonable attempts to collect outstanding balances fail, account in poor standing will be outsourced to a third-party for collections.

Third Party Liability: This means that someone else's insurance is to cover your illness/injury, such as workers compensation or from a motor vehicle accident. We do not file charges for payment to any third-party payor. These instances will require you to work through the required provider per the third-party. We apologize for any inconvenience.

Urine Drug Screens: There are certain medications that the Drug Enforcement Agency requires all providers to monitor their distribution. Due to this you may be asked to return every 30 or 90 days for drug testing, as necessary, to have medications that are controlled refilled.
PLEASE ENSURE YOU ACCESS THE PATIENT PORTAL, ONCE ESTABLISHED, TO REQUEST APPOINTMENTS, CHECK RESULTS AND REQUEST REFILLS

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PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Mobile Phone: _____ Home Phone: _____

Sex: ☐ Male ☐ Female ☐ Other Social Security Number: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Phone: _____ Address: _____

PARENT / GUARDIAN INFORMATION

If patient is under 18 or insurance is in parent/guardian's name, please fill out the following:

Father/Guardian Name: _____ Phone: _____

Mother/Guardian Name: _____ Phone: _____

PATIENT MEDICAL HISTORY

Previous Primary Care Provider: _____

Pharmacy Name: _____ Location: _____

INSURANCE INFORMATION:

Primary Insurance: _____

Member ID Number: _____ Group/Policy Number: _____

Insurance holders name: _____ DOB: _____

Effective/ issued Date: _____ Expiration/ Termination Date: _____

Secondary Insurance: _____

Member ID Number: _____ Group/Policy Number: _____

Insurance holders name: _____ DOB: _____

Effective/ issued Date: _____ Expiration/ Termination Date: _____

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ALLERGIES:

Medication	Reaction

SOCIAL HISTORY:

Marital Status:	Single	Married	Widowed	Divorced	Legally separated	
Number of Children:		**Occupation:**				
Ethnicity and/or Race (Mark all that apply)	White	African American	Hispanic or Latino/ Spanish	Hawaiian/Pacific Islander	Indian	Not Hispanic or Latino/ Spanish
	Asian	American Indian	European	Other	Decline to Answer	
Last level of education:						

CURRENT MEDICATIONS:
(Including all prescribed medications, vitamins, herbal supplements):

NAME	DOSE	FREQUENCY
*Please bring all medication bottles to all appointments **Provide medication list document or write on back if needed		

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PAST SURGICAL HISTORY:

SURGERY	YEAR (if known)

MEDICAL HISTORY:

Please select all current and past medical problems you've been diagnosed with:

- ☐ Hypertension (High Blood Pressure)
- ☐ Diabetes-Last A1C: _____ Date_____
- ☐ High Cholesterol
- ☐ Thyroid Disorder: LOW HIGH
- ☐ Anemia – Type: _____
- ☐ Seizure Disorder / Epilepsy
- ☐ Migraines
- ☐ CVA (Stroke)/ TIA (Mini-Stroke)
- ☐ Memory Difficulties
- ☐ Liver Disease – Type: _____
- ☐ Kidney Disease – Type: _____
- ☐ Glaucoma
- ☐ Heart Disease – Type: _____
- ☐ GERD (Chronic Heartburn)
- ☐ Autoimmune Disorder – Type: _____
- ☐ Chronic Pain – Body Part(s): _____
- ☐ Abnormal Pap Smear / HPV
- ☐ Urinary Incontinence
- ☐ Asthma
- ☐ COPD / Emphysema
- ☐ Seasonal Allergies
- ☐ Depression/ Anxiety
- ☐ Other Mental Health Issue - _____
- ☐ Substance Abuse - _____
- ☐ Sleep Apnea
- ☐ Cancer – Type: _____
- ☐ Other: _____

FAMILY HISTORY:	MAJOR MEDICAL CONDITIONS	DECEASED?	AGE DIAGNOSED (IF KNOWN)
Father			
Mother			
Brother(s)			
Sister(s)			
Other:			

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ANXIETY SCREENING: GAD-7

Name: _____
DOB: _____
Date: _____

Over the <u>last 2 weeks</u>, how often have you been bothered by the following problems?					
1	Feeling nervous, anxious, or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless that it's hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid as if something awful might happen	0	1	2	3
	Add up Each Column:	0			
				Total Score:	

Scores Represent:		
0-4	5-9	10-14
None - Minimal	Mild	Moderate

Name: _____
DOB: _____
Date: _____

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DEPRESSION SCREENING: PHQ-9

Over the last 2 weeks, how often have you been bothered by the following problems?		Not at all	Several Days	Over Half the Days	Nearly Everyday
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things such as reading the newspaper or watching TV	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or hurting yourself in some way	0	1	2	3
	Add up Each Column:	0			
				Total Score:	

If you checked yes to any of these problems above, how difficult have these problems made it for you to do your work, take care of the things at home or get along with other people? 0 | 1 | 2 | 3

Scores Represent:				
0-4	5-9	10-14	15-19	20-27
None - Minimal	Mild	Moderate	Moderately Severe	Severe

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Name: _____ Date of birth: _____ Date: _____

Have you had any major changes to your health or surgeries within the past year?

_____

_____

Have any of your immediate family members suffered from major medical conditions in the past year?

_____

Please take a moment to fill out these questionnaires below so we can provide you the best care:

		Not at all	Several days	More than half the days	Nearly every day
1.	Little interest or pleasure in doing things	0	1	2	3
2.	Feeling down, depressed, or hopeless	0	1	2	3
3.	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4.	Feeling tired or having little energy	0	1	2	3
5.	Poor appetite or overeating	0	1	2	3
6.	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7.	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9.	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you checked yes to any problems above, how difficult have these problems made it for you to do your work, take care of the things at home or get along with other people? 0 | 1 | 2 | 3

C	Have you ever felt the need to **cut** down on your drinking or drug use?	Yes	No
A	Have people **annoyed** you by criticizing your drinking or drug use?	Yes	No
G	Have you ever felt **guilty** about drinking or drug use?	Yes	No
E	Have you ever felt you needed a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (**Eye-Opener**)?	Yes	No

_____

How many alcoholic drinks do you drink a day? _____

How many alcoholic drinks per week?

_____

Name:

_____ Date of Birth:_____

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Please check each symptom that you have now or that is chronic/recurrent:

General Fever Weight Loss Weight Gain	Lungs Cough/Wheeze Shortness of breath Sleep apnea Chest wall pain	Skin Open sores Rashes Changes in moles
Eyes Pain Dryness Vision change	Abdomen Abdominal pain Diarrhea Constipation Heartburn	Neurologic Headaches Tremors/Restless legs Memory loss Imbalance/Falling
Head Head injury Hearing changes Nose bleeds Sinus problems Teeth problems	Urinary Incontinence Difficultly Urinating Increased Frequency Abnormal Vaginal Bleeding Erectile Dysfunction	Psychiatric Anxiety Depression Sleep disturbance Alcohol or drug abuse
Heart Chest Pain Palpitations Swelling of extremities	Skeletal Back pain Joint pains/ swelling	Endocrine Fatigue Increased thirst Heat/Cold intolerance

Medicare Patients ONLY:

Draw a clock below with all its numbers

and set the time for “10 after 11”.

Have you had any significant falls or broken bones in the last year?	Y / N
Do you have concerns with eating a healthy diet or getting regular exercise?	Y / N
Are there concerns with your ability to concentrate, or do you have difficulty with memory lapses or forgetting words?	Y / N
Is it difficult to do fine motor tasks like writing/copying, or do you regularly knock things over with picking them up?	Y / N
Do you wear glasses or hearing aids?	Y / N
Do you have difficulties with bathing, dressing, feeding or toileting yourself with limited assistance?	Y / N
Are there concerns with you managing money or medications independently?	Y / N
Do you have concerns doing housework, grocery shopping or working a phone with limited assistance?	Y / N
Are there concerns with smoke detectors, lighting, grips under rugs or firearms (if applicable) being safely stored at home?	Y / N

_____

Do you have a Living Will and?

Medical Power of Attorney? Yes / No

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Name:_____
DOB:_____
Date:_____

EPWORTH SLEEPINESS SCALE

0	1	2	3
Would ***never*** doze	***Slight*** chance of dozing	***Moderate*** chance of dozing	***High*** chance of dozing

	Chance of Dozing			
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place (e.g., a theater or a meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3
	TOTAL SCORE:			

Interpreting Epworth Sleepiness Scale Scores		
Normal	**EDS***	**High Levels of EDS***
0-10	> 10	> 16