

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 as 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 (AWW) 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

Please circle Provider of Choice:

Sarah Harris FNP-C Tausha Rhoades AGACNP-C Madison Odom PA-C Hannah Revell FNP-C

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: _____
Current Specialists/Other doctors: _____

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: _____

1016, 1025 & 1027 Keith Dr
Perry Ga 31069

PERRY

PRIVIA
MEDICAL GROUP

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

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		

PAST SURGICAL HISTORY:

SURGERY	YEAR (if known)

MEDICAL HISTORY:

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

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

For women: abnormal Mammogram

Date of last Mammo: _____

For women: osteopenia/osteoporosis

Date of last Bone Mineral Density Study: _____

For women: abnormal Pap Smear / HPV

Date of last Pap: _____

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?

FAMILY HISTORY	MAJOR MEDICAL CONDITIONS	DECEASED	AGE DIAGNOSED (IF KNOWN)
FATHER			
MOTHER			
BROTHER(S)			
SISTER(S)			
GRANDMOTHER:			
GRANDFATHER:			

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

<p>General</p> <ul style="list-style-type: none"> <input type="checkbox"/> Fever <input type="checkbox"/> Weight Loss <input type="checkbox"/> Weight Gain 	<p>Lungs</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cough/Wheeze <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Sleep apnea <input type="checkbox"/> Chest wall pain 	<p>Skin</p> <ul style="list-style-type: none"> <input type="checkbox"/> Open sores <input type="checkbox"/> Rashes <input type="checkbox"/> Changes in moles
<p>Eyes</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pain <input type="checkbox"/> Dryness <input type="checkbox"/> Vision change 	<p>Abdomen</p> <ul style="list-style-type: none"> <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Heartburn 	<p>Neurologic</p> <ul style="list-style-type: none"> <input type="checkbox"/> Headaches <input type="checkbox"/> Tremors/Restless legs <input type="checkbox"/> Memory loss <input type="checkbox"/> Imbalance/Falling
<p>Head</p> <ul style="list-style-type: none"> <input type="checkbox"/> Head injury <input type="checkbox"/> Hearing changes <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Sinus problems <input type="checkbox"/> Teeth problems 	<p>Urinary</p> <ul style="list-style-type: none"> <input type="checkbox"/> Incontinence <input type="checkbox"/> Difficultly Urinating <input type="checkbox"/> Increased Frequency <input type="checkbox"/> Abnormal Vaginal Bleeding <input type="checkbox"/> Erectile Dysfunction 	<p>Psychiatric</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Sleep disturbance <input type="checkbox"/> Alcohol or drug abuse
<p>Heart</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Swelling of extremities 	<p>Skeletal</p> <ul style="list-style-type: none"> <input type="checkbox"/> Back pain <input type="checkbox"/> Joint pains/ swelling 	<p>Endocrine</p> <ul style="list-style-type: none"> <input type="checkbox"/> Fatigue <input type="checkbox"/> Increased thirst <input type="checkbox"/> Heat/Cold intolerance

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PHQ2 – Over the past 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than ½ days	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				

How many alcoholic drinks do you drink per day? _____ How many per week? _____

Tobacco Screening			
Do you or have you ever smoked tobacco or use(d) smokeless tobacco? (CIRCLE)	NEVER SMOKER	FORMER SMOKER/YEAR QUIT	CURRENT SMOKER
How many years using tobacco?	_____ years	How many packs per day?	_____ PPD